ABSTRACT OF

The Brown Lectures.

FURTHER INVESTIGATIONS ON ANTHRAX AND ALLIED DISEASES IN MAN AND ANIMALS.

BY PROF. W. S. GREENFIELD, M.D., F.R.C.P.

LECTURE IV.

BEFORE discussing the minute anatomy and the pathology of "woolsorters' disease," Dr. Greenfield gave an account of the cases of anthrax (splenic fever) in the cow and sheep, which had apparently arisen from drinking water in which infected wool or hair had been washed, and showed that these cases were proved by the microscope and by experiments to be really cases of anthrax. Moreover, they were of interest from the fact that the examination of the various fluids from these animals side by side with those from men showed the identity of the conditions in both.

Passing next to the microscopical anatomy of anthrax in the lower animals, he described the various appearances usually met with in splenic fever of cattle and in animals inoculated from them. The multiple ecchymoses found in various organs were shown to be usually due to thrombosis of vessels by masses of bacilli, not uncommonly the artery or vein being filled by a plug consisting entirely of bacilli, and the extravasated blood containing them only in very small numbers. This was especially the case in the heart, lung, and brain, but occurred also in other situations. It might be, however, that the bacilli, especially in the lung, were far more widely distributed, occupying in large numbers the pulmonary capillaries throughout a wide area of the lung. In the lymphatic glands and spleen they might be almost entirely limited to veins and venous sinuses, or more widely diffused. In the kidney the glomeruli, particularly those nearest the surface of the cortex, were their especial site, where they occupied and often filled the glomerular capillaries. He stated, however, that in some cases this general distribution of the bacilli was not observed, but they were almost entirely limited to certain organs, especially the lungs, and in one case to certain vessels supplying some of the bronchi, where they produced special changes.

Turning next to the subject of human anthrax, he described the changes found in the malignant pustule, following the descriptions of Davaine, Thiersch, Wagner, and Colin, and stating that he had had no opportunity of studying them for himself in man. He believed, however, from observations on the lower animals, that whereas in the majority of cases the infection of the general system occurred through the lymphatic glands, it was not at all improbable that the virus might enter the blood-stream locally through the capillaries of the affected part, and that this partly accounted for the great difference in the results of equally severe local affection. The theory of double parasitism of bacilli and micrococci, advocated by Buchner to account for the local phenomena, he did not think supported by the evidence.

The internal form of anthrax known as "woolsorters' disease" was next considered. Dr. Greenfield pointed out the far greater difficulty usually met with in the examination of the organs for bacilli in man, owing to their relatively small number and the length of time which must usually elapse before the post-mortem examination—a fact which always increased the difficulty in discovering them. After briefly adverting to the principal changes found in the organs as described in the previous lecture, these especially consisting of ecchymoses in the trachea and bronchi, great engorgement of the bronchial glands, mediastinal cellulitis, and pleural effusion, he described in detail the microscopical changes found in these cases. In two of the most complete cases, in which he was able to examine nearly all the organs of the body, he found the following conditions. In the lower part of the trachea and larger bronchi masses of bacilli were found occupying the lymphatic plexuses of the mucous and submucous tissue, and extending to near the surface of the mucous membrane. In some parts these were almost unattended by any marked change in the surrounding tissues; but where the change had proceeded to any extent, marked inflammation was present. Of the earliest changes observed, hæmorrhage into the mucous membrane and hæmorrhagic exudation upon its surface, leading to detachment of the epithelium, were the most common, in some cases the epithelial layer being raised entire, so as to form a sort of bulla on the surface. In the more advanced stages the entire mucous membrane was infiltrated with blood, so as to form a raised area, the deeper parts of the mucous membrane showing signs of inflammation, and being crowded with bacilli. No distinct ulceration was anywhere observed. Dr. Greenfield was also able to trace the course of absorption of the virus, as indicated by the presence of masses of bacilli along the lymphatics surrounding the arteries and bronchi, where they were found in some places in great abundance, whilst in other parts of the lung they could not be found at all, or only one or two here and there. In the bronchial glands, which in the majority of sections examined were completely infiltrated with blood, bacilli were found, but not in great abundance except in the bloodvessels of the cortical part, which were in many cases plugged by bacilli. The glands most especially affected were those situated at the bifurcation of the trachea, and might have become so by direct continuity from the larger bronchi. Hence Dr. Greenfield thought it probable that the primary affection was that of the bronchial mucous membrane, and that both the glands and the general system were secondarily involved. In the lung nothing special was found beyond some collapse, due to bronchial obstruction and to the pleural effusion, and in some parts commencing broncho-pneumonia. In other cases there were areas of hæmorrhage, corresponding with those seen in the lungs of lower animals when the arteries are obstructed. In the other organs no special changes beyond what are common to most febrile diseases were discovered, except where hæmorrhage had occurred in various organs. Bacilli were found scantily distributed in the blood in sections of vessels.

Passing, then, to the question of the source and mode of entrance of the virus, Dr. Greenfield described the mode of woolsorting and the conditions under which infection occurs. Neither microscopical examination nor experiments had been able to prove that the wool was the source of the infection, but the circumstantial evidence appeared conclusive that such was the case. Nor had experiments with the water in which wool had been washed been more satisfactory. But the difficulties in the investigation were so great that a negative result was not surprising.

As to the channel by which the virus enters the system, although the bronchi or lungs would appear most probable, from the origin of infection, course of symptoms, and results of pathological investigation, it could not on these grounds alone be conclusively adopted, for some cases of inoculation by the skin presented very similar pulmonary lesions. But skin inoculation in man gave rise to a definite local lesion; this might therefore be excluded. Inoculation in some part of the alimentary or respiratory tracts remained therefore for consideration.

Experiments by Böllinger, Pasteur, Toussaint, Feser, Chauveau, and others, have shown that even large quantities of anthrax virus may pass through the alimentary canal of susceptible animals without injury, unless some irritant particles capable of causing abrasion are present. Buchner has recently shown that large quantities of spores mixed with the food of white mice may pass unaltered through the greater part of the alimentary canal, being gradually destroyed by digestion, but producing no results, whilst inoculation with the contents of their intestines in small quantity causes fatal effects. Similar experiments which Dr. Greenfield had made by feeding with infected food had a like negative result.

On the other hand, it has been conclusively shown that inhalation of spores will give rise to infection, though Buchner's experiments seem to show that the result is very largely attributable to the material in which they are conveyed, and that powdered charcoal and talc are by far the most suitable. The short particles of hair found in the wool or hair-dust would, Dr. Greenfield thought, furnish a similar irritant vehicle in inhalation of infected hair. Moreover, if inoculation had occurred through the alimentary canal the lesions produced would probably have had some resemblance to those in Wagner's cases of "intestinal mycosis." From these considerations Dr. Greenfield considered it almost con-

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clusively established that the majority of cases of "wool-sorters' disease" are a form of anthrax produced by inoculation through the mucous membrane of the bronchi, a "bronchial" as distinguished from an "intestinal" mycosis. Other cases might show that inoculation sometimes occurred through other channels. The subsequent course of infection was probably through the lymphatic and bronchial glands. Dr. Greenfield had not found any particles of hair in the alveoli in scores of sections of the lungs in these cases.

With regard to the other changes found, the pleural effusion might probably be due partly to an altered condition of the blood, but still more to the complete obstruction of the bronchial lymphatic glands. It did not appear in any case to be inflammatory, nor was any other obvious cause present. Probably this great pleural effusion was often the immediate cause of death.

As to the symptoms observed, these appeared to be closely related to the changes discovered; very probably the obstinate vomiting sometimes observed was due to implication of the vagus and phrenic nerves in the mediastinal inflammation, and this might also account for the rapid and irregular action of the heart. The convulsions had been attributed to asphyxia, but might equally be due either to direct affection of the brain, toxæmia, or uræmia, the latter being indicated by the condition of the kidneys.

The incubation period was next discussed, and the statistics from a large series of experiments by various observers, and by Dr. Greenfield himself, were collated, as well as cases in man. From these he concluded that in many cases a period of four and a half or five days elapsed between the exposure to infection and onset of symptoms in man, a longer period than usual in lower animals, but that there was probably great variation in this respect, and the known facts were not yet sufficiently numerous to justify an absolute conclusion.

As to the diagnosis of the disease; with our present knowledge it must largely depend on known exposure to infection, and this very probably accounted for its not having been recognised in regions where it almost certainly existed. From ordinary acute pneumonia it might be usually distinguished by the absence of early elevation of temperature, the absence of the usual physical signs, and of rusty sputum, the marked depression out of proportion to the local symptoms, and the rapid cyanosis, usually with signs of double pleural effusion. But in the very rapid cases death often occurred whilst the case was still regarded as one of ordinary bronchitis, and in the prolonged cases secondary broncho-pneumonia might occur, and complicate the diagnosis. Moreover, it might simulate various unusual forms of latent pneumonia associated with renal and other diseases.

The diagnostic value of anthrax bacilli in the blood had been overrated, for very frequently they might be so limited to the affected regions until very near the time of death, or shortly after, that repeated examination of the blood would fail to detect them in the earlier stages of the disease. Hence it was but very rarely that their discovery would serve to establish the diagnosis. After death, before decomposition occurred, the presence of bacilli of the size and form of anthrax bacilli, without other bacteria, would be distinctive, but after decomposition had set in the presence of similar bacilli with other bacteria was inconclusive. The only certain test, inoculation, was also usually negative when decomposition had set in. But if on cultivation of blood in the warm stage the bacilli do not develop, but degenerate, they are probably not due to decomposition, as the bacilli formed in putrefying blood will, under these conditions, continue to develop in the presence of other bacteria. Dr. Greenfield also discussed other points relating to the distinction of anthrax bacilli.

In conclusion, he remarked that the observations which he had detailed, when combined with recent researches on the contagion of malarial fevers, relapsing fever, and fowl cholera, were of great suggestive value in relation to the pathology of contagion, making some of the difficulties hitherto felt in accepting the bacterial view of contagion much less than they had hitherto appeared. At the same time we ought not for a moment to allow any discovery, however important, to be extended beyond its own special and legitimate conclusions with regard to the particular disease in question. But these observations should lead to the investigation of other contagia along the lines indicated by determined facts.

It was now clearly shown that the diseases in question followed the same laws of non-recurrence or modified recurrence as other specific fevers, that they were attended by specially localised and specific lesions. The bacteria formed the contagium follow special laws of growth and distribution within the body, which are not explained by any mere chemical affinity or physical qualities. They must be regarded as parasites, which both within and without the body are selective as regards their host and the parts which they affect, and in the changes they undergo and produce, and are governed by definite laws specially related to the class of animals and the individuals which they infest. External to the body they may, under suitable conditions of growth, become modified in their properties, or even lose their morbific action. Within the body they may be innocuous, owing to the insusceptibility to their action, and may be simply destroyed or excreted. They may also be periodical in their times of diffusion, as well as selective in point of locality.

LECTURE V.

This lecture took the form of a demonstration, with remarks, of microscopical specimens, and of a series of micro-photographs prepared by Dr. Maddox, which were shown with the limelight by Dr. W. H. Stone.

The series of photographs illustrated the changes undergone by the anthrax bacillus in its growth, and the continuance of the characters unaltered through a series of generations of cultivation. Together with these, photographs of the blood and the fluids from cases of human anthrax ("woolsorters' disease") were shown; and also organs of various animals dying of anthrax.

The microscopical specimens were also illustrative of the subjects of the lectures, upwards of sixty microscopes being shown. Complete series of cultivations of the anthrax bacillus under high powers were exhibited, and other bacilli liable to be mistaken for them. Other series of preparations showed the changes found in splenic fever in the lower animals, and those discovered by Dr. Greenfield in "wool-sorters' disease."

Clinical Lecture

ON THE

DIAGNOSIS & TREATMENT OF RINGWORM.

Delivered at St. Mary's Hospital Medical School,

BY MALCOLM MORRIS, F.R.C.S. EDIN.,

JOINT LECTURER ON DERMATOLOGY.

GENTLEMEN,—Ringworm, no matter what part of the body may be affected, is essentially a localized eczema produced by a local cause. The local cause is a microscopic fungus which has a peculiar affinity for the epidermic structures of man and certain animals. There are some who deny that the phenomena seen on the skin to which we are accustomed to apply the term ringworm are due to this vegetable growth; but I will ask you to accept the theory as established, inasmuch as it is the opinion of the majority of dermatologists, both English and foreign.

During my observations I will ask you, then, to assume that this fungus—which is known as the Trichophyton tonsurans—is the primary cause of all the changes on the skin known as ringworm. It is found that these changes differ in appearance according to the part on which the fungus is deposited, and the fact is clearly due to the anatomical differences of the epidermic structures. But in spite of these differences the principle involved is the same—the fungus, as a foreign body, acting as an irritant and causing an eczema. The strongest argument in favour of the parasitic theory is the pre-eminently contagious character of the disease. We find that if a child suffering from ringworm be accidentally admitted into a school, after a short interval several of the other children give evidence of having been attacked in a similar manner. Occasionally, however, cases are met with in which children kept under close supervision develop ringworm, although there is apparently no history of contagion. In such circumstances I think there is little doubt that the disease has been caught from domestic animals, usually cats. As regards the physical characters

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of the parasitic plant, I refer you to the text-books on the subject, and especially to the excellent description by Kaposi in the fifth volume of Hebra, published by the New Sydenham Society. To-day I wish to call your attention to the various stages and changes produced by its presence, and to consider what are the indications for treatment in consequence.

In the initiation, fungus is carried in minute particles either in the air (Bazin) or by means of the clothes on to the epidermis; here it is deposited, and, if the soil is suitable and there is sufficient warmth and moisture, it commences to grow. Passing then between the horny cells of the epidermis, it finds its way into the deeper layers, where by the irritation of the more organised cells it sets up the first stage of a simple inflammatory process—viz., hyperæmia. A red spot, then, is the first subjective symptom in ringworm in every case, whether the part be covered with hair or not. Next in order comes the formation of a ring of inflammatory papules, the second stage of a true eczema, and the circle continues to widen with the growth of the fungus. The acute inflammatory symptoms may here cease, or indeed, as is the case in all eczemas, they may abort at any stage as a result of a removal of the cause. But should the condition become more intense, the papules will become the seat of vesicles; and although these vesicles have nothing peculiar in themselves, the fact of their being distributed more or less in a ring will lead to the suspicion that the disease is ringworm. Authors have recognised the three stages I have mentioned, and have given such descriptive names to the disease as tinea maculosa, tinea papulosa, and herpes tonsurans. As the ring spreads we shall find that the hyperæmia within the centre disappears, and in consequence of the interference with the growth of the cells a branny desquamation will be observed on the surface. In addition to the foregoing appearances, if the part attacked be hairy, the hairs themselves not at first affected speedily become diseased. The fungus may be deposited either on a hair or in the mouth of a hair-follicle. Thus it may grow downwards into the follicle or it may get there by extension from the deeper layers of the epidermis. As soon as it reaches the deeper part of the follicle it interferes with the nutrition of the hair, and thus causes it to break off a short distance from the mouth of the follicle, leaving a projecting stump. This stump is usually split or twisted, and has lost its natural healthy appearance; moreover, it lies but loosely in the follicle.

A recent patch of ringworm of the scalp, for example, can easily be diagnosed by the raised red ring of papules, some of which may be vesicular, with a more or less pale, slightly pigmented centre, covered with branny desquamation and short broken hairs that are readily extracted.

To pass now to the more chronic and obstinate forms of the disease. As far as English ringworm is concerned, the parts attacked are limited to the scalp, for the disease when found on non-hairy parts is quickly and easily cured; I am now speaking of English ringworm only. There is, I have understood from Indian medical officers and surgeons who have practised in China and other parts of the East, a variety of the disease which attacks the body, and is most inveterate and difficult to cure. Why this is the case I cannot tell you, but one would be inclined to imagine that the heat and the moisture on the skin would so favour the growth of the plant as to make it reach a higher state of organisation than it attains in this country. At all events, the eczema produced is undoubtedly the same, though of a more severe type, and the fungus is harder to destroy.

Acute ringworm may pass into one of two conditions:—1. It may become pustular. 2. It may become dry and squamous. Pustular ringworm of the scalp is a most important stage of the disease to recognise, as there is danger that the cause may be overlooked. It may also assume either a superficial or a deep form. If superficial, the appearance is that of pustules at the mouths of the hair-follicles, which burst and cause fresh pustules to be produced by the pus being transplanted to other parts of the head. Thus a contagious impetigo, or porrigo, is the result. As the pus dries large yellowish scabs are formed, from beneath which the pus exudes. When the scabs are removed some of the short broken hairs come away with them, and small bald patches are left in consequence. In the deep-seated variety the pus is formed in the substance of the follicle, and as it passes to the surface through the neck of it, by mixing with the sebaceous matter, it becomes somewhat thinner than ordinary pus. The effect of inflammation in the follicles is to cause the part to become raised and tender, and to have the appearance of a subcutaneous abscess. The condition is known as *kerion*. As the process continues the hairs fall out, oftentimes leaving permanent bald patches.

We now come to the second variety—viz., squamous ringworm. This is the commonest and the most chronic form of the disease. Sometimes it is seen in small localised patches corresponding in size to the original acute patch, at others it will cover the whole scalp. In the latter case it may be called by a term I have employed elsewhere—"diffuse ringworm."[1] In both these forms all signs of acute eczema have disappeared, but in their place has been produced a dry squamous eczema. The localised patches are easily recognisable, resembling, as Kaposi remarks, badly executed tonsures by reason of being covered with short broken hairs. The "diffuse" variety, on the other hand, is very often overlooked and treated as a simple eczema, in which case it will probably last for years. Gentlemen, I should advise you to be exceedingly cautious before you give a certificate that a case of ringworm is cured, for you may by carelessness in this respect cause endless trouble to a great number of people. It is when describing this variety that a word of caution needs to be spoken, for although you would not be likely to give a certificate if you saw a well-defined patch, you might very easily be led to agree with an anxious parent who had learnt to call the case simple eczema. "My child has had ringworm, and now we cannot get rid of the scurf on the head," is a remark I am told constantly, and as constantly after making a careful examination with a little patience do I succeed in finding fungus. The disappointment of the parents on being confronted with such a result can be imagined, for in many instances it has transpired that they have been told by other medical men that the case was well. In fact, even in cases where I have spoken with authority from the revelation of the microscope my opinion has been doubted, the former faulty but favourable view had so strongly possessed the parents. Diffuse ringworm is the most chronic and the most difficult to cure. In this I am supported by the opinion of the distinguished medical officer of Christ's Hospital, Dr. Alder Smith, who in an able article,[2] recently published, says, "Especially would I call attention to a variety I call 'disseminated ringworm,' one rarely diagnosed, and the most chronic and difficult to cure."

It is my wish to-day to make this troublesome condition clear to you, for I am certain that if it were recognised by surgeons generally, we should hear much less of ringworm in our schools. It is extremely contagious. I think I shall be well within the mark if I say that, if left untreated, it is a more contagious condition than any other stage of the disease. The reason is that the scalp is so dry that the particles are easily disseminated in the air, and settle on the skins of other children.

Here I would digress for a moment to consider the class of persons principally affected with this disease, as it will assist us both in our diagnosis and treatment. Children are much more prone to take it than adults, and especially on the scalp. I have seen only three cases so situated in adults. One was a governess who caught it from the children she had under her care. Occasionally in adults it attacks the beard, when it deserves the name of sycosis parasitica. It is not at all uncommon for adults to get it on the body, and it usually occurs when they are attending to children who have it on the head. As regards the children themselves, I believe it depends greatly on the character of the hair and epidermis—first, as to whether they get it at all, and, secondly, as to the length of its duration. To explain my meaning more clearly, I have grouped children into three classes:—

	Hair.	Eyes.	Epidermis.
1	Black or dark brown	Dark brown	Thick
2	Brown (medium)	Blue-grey, grey-blue, or grey-brown	Medium
3	Very light brown, golden or colourless	Light grey or blue	Fine skin with thin epidermis

The first class but rarely suffer from ringworm, the third take it easily and usually have it severely, very often the pustular variety. The second class, both as regards severity and readiness of infection, stand midway between the other two

[1] Manual of Skin Diseases, p. 288.
[2] THE LANCET, January 10th, 24th, 31st, 1880.

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classes. If, therefore, you get a child answering to the description of either the second or third class with either a pustular or dry scaly disease limited to the scalp, I would advise you to suspect ringworm.

To return to the diagnosis of the diffuse squamous variety. The whole, or a greater part, of the scalp is covered with white powdery scales that fall off easily, the hair is thin, dry, and lustreless, while here and there a few short broken hairs are to be found, which are easily extracted. *These short hairs are often extremely difficult to find, and because, in a superficial examination, you cannot at once find them, it will not be right to conclude that they do not exist.* At times I believe they are so short that their ends are hidden amongst the loose epidermis. In order to find them, instead of picking with forceps, scrape the part gently with a knife. By this means you will be able to get some of the small stumps. Place the stumps, together with portions of the epidermis, in liquor potassæ, and examine microscopically, and you will find fungus.

(To be concluded.)

THREE CASES OF SUDDEN OBSTRUCTION OF THE ABDOMINAL AORTA BY ANEURISM; WITH REMARKS.

BY J. S. BRISTOWE, M.D., F.R.C.P.

(Concluded from page 133.)

CASE 3.—*Aneurism of upper part of abdominal aorta; rupture and subperitoneal extravasation of blood; aortic obstruction; albuminuria and infarcts in kidney; partial paraplegia; death.*—W. L——, an engine-driver, forty years of age, came under my care on June 17th, 1880. He had had clap and syphilis, but otherwise had enjoyed good health till the commencement of his present illness. In 1865 he went to India as an engine-driver, and continued well until eleven months ago, when he began to suffer from pain in the lumbar region, associated with constipation. The pain soon became so constant and severe as to wholly incapacitate him for work. He went first into some local hospital, where he was treated for lumbago, without relief; and subsequently into the General Hospital at Calcutta, where he was treated mainly with purgatives, and derived, as he thought, some benefit.

On admission, he was a florid, healthy-looking man. He complained of pain in the left lumbar region, not constant, but coming on in paroxysms at irregular intervals. It was always worse at night, and was aggravated by walking or even sitting up in bed. It was generally of a dull, aching character, but at times becoming acute and lancinating. He had also an occasional burning sensation running down the fronts of both thighs to the knees. The pain prevented him from sleeping. He had slight tenderness in the left lumbar region, and over the left sacro-iliac articulation, but no enlargement. Tongue coated; appetite poor; bowels constipated, the motions being hard and scanty; heart sounds and action normal; pulse 66; lungs apparently healthy, no cough; abdomen not distended, nor tender on pressure; no tumour detected in it; urine, sp. gr. 1018, phosphates, no albumen. Temperature 99°.

He remained much the same until the 26th. The pain continued off and on with extreme severity, and was generally referred to a region a little above the centre of the crest of the left ilium; but he had also pain in the back, and at times pain across the abdomen below the umbilicus; he also had an occasional sense of numbness down the front of both thighs to the knees. The symptoms were relieved by the subcutaneous injection of morphia, and the application of a blister. The urine continued in fair abundance, of rather high specific gravity, and free from albumen.

26th.—About 8 A.M. had a very severe attack of lumbar pain, lasting for about half an hour, and then relieved by a morphia injection. He rolled himself about in bed, buried his face in the bedclothes, and cried out in agony. The pain was referred to both lumbar regions, scarcely extending into abdomen, but running down both legs, mainly the left. No sickness during attack. The temperature remained normal.

27th.—No urine passed for twenty-four hours. During the morning about three ounces were voided. It was thick, contained two-thirds albumen, and, microscopically, large granular casts, blood casts, free blood cells, and dumb-bell crystals of uric acid. The temperature varied during the day from 100° to 101·4°.

28th.—Passed six ounces of urine in the last twenty-four hours. Temperature in the morning 98·1°; in the evening 98·6°.

29th.—Passed seven ounces of urine in the last twenty-four hours. It still contained albumen, blood, and free blood cells. No casts or crystals discovered. He does not complain much of lumbar pain; but he has severe pain extending down front of left leg, and seems to have some difficulty in walking. Temperature normal. Under the use of morphia he has been free from paroxysms of pain since the 26th.

30th.—In the morning it was noted that his tongue was dry and brown; that his bowels were confined; that he had much pain in abdomen and down left leg, with occasional numbness in both feet; and that he had only passed four ounces of urine in the previous twenty-four hours. The specific gravity was 1022; it contained half albumen and blood. Temperature 98·6°. Noon: Was attacked very suddenly with increase of lumbar pain, slight sickness, and collapse. When the house-physician, who was sent for, arrived, the following was the patient's condition:—"Deadly pallor of face and lips, and rest of body. Pupils equal, small. Respirations moaning; pulse 204, scarcely perceptible. Complains of great pain in lumbar region and down legs. A diffused tumour, which has appeared since the morning, is felt in the left iliac region. No pulsation or bruit detectable over tumour or in abdomen, and no pulsation to be felt in arteries of lower extremities. Legs cold, but not colder than rest of body. They are numb, and he can scarcely move them. Can move right better than left." A little later he complained of a burning sensation in feet and inner side of thighs. Temperature 97°. 1.15: Lips and face corpse-like. Cold sweats. Pulse 122, barely perceptible; respirations sighing, but not frequent. He has a little hiccough. No urine passed. Has had no pain since morphia injection given about an hour ago. 1.50: Eyes fixed; pupils dilated; pulse not to be felt; occasional spasmodic startings of arms. Died at 2.10.

Post-mortem, July 1st.—Body fairly nourished. Chest: A little serum in pleuræ; lungs healthy; pericardium and heart healthy, the latter weighed thirteen ounces; thoracic aorta healthy. Abdomen: On opening the abdomen a large effusion of blood, in the form of a dark, soft coagulum, was found in the subperitoneal tissue on the left side, chiefly abundant in the neighbourhood of the left iliac fossa, and extending thence beneath the peritoneum of the abdominal wall anteriorly. It was not very abundant immediately in front of the spine. A large tumour was now discovered mainly on the left side of the abdomen, but extending across the median line to the right, beneath the liver. It was somewhat like a kidney in shape and suggested a renal tumour. On careful examination, however, the left kidney was found simply pushed upwards and forwards and resting on a large soft mass behind it. The tumour consisted partly of an aneurism of the abdominal aorta and partly of effused blood, the consequence of its rupture. The aneurism was saccular and came off from the posterior aspect of the aorta just where it gives off the cœliac axis and superior mesenteric. Its orifice of communication with the aorta measured two inches longitudinally. The inner coat of the aorta could only be traced for a short distance into the sac, and ended by a free irregular edge. It was not possible to say exactly how far the aneurism extended, or where the clot due to the aneurism ended and that which resulted from the rupture commenced, for the old and new clots were a good deal intermingled. The quantity of hard partially decolorised clot showed, however, that the aneurism must have been a large one, as also did the extensive erosion of the vertebræ which was present. This involved the last two dorsal and upper three lumbar vertebræ. None of the arteries springing from the abdominal aorta nor the aorta itself was plugged with clot and indeed they were pervious. But the disarrangement of clot in the aneurism and the pressure of the accumulated blood around not improbably caused more or less complete obstruction to some, at any rate, of these vessels. The left renal artery, from the stretching and displacement which it had undergone, was especially likely to have been rendered impervious. Liver and spleen were healthy. Right kidney somewhat congested, otherwise healthy. The left kidney was large and contained several large well-defined hæmorrhagic infarcts; one, occupying one-quarter of the organ,

was pinkish-white in colour, and not harder than the rest of the kidney. Around it was a rim of very slight congestion.

Remarks.—The opinion first entertained by those under whose care the patient came, with respect to the first of my three cases, was that he was suffering from heart disease, and that the aortic obstruction, which was manifestly present, was due to embolism. This view I could not accept, because, first, in my opinion there was no evidence of heart disease, at any rate of such heart disease as could give rise to an embolus sufficiently bulky to occlude the aorta; and, second, according to my reading and experience, such sudden obstructions are generally, if not always, owing to the presence of aneurism. My own belief was that the patient, suffering from aortic disease, had suddenly experienced rupture of the internal coat of the artery at its highest part, with the development of a dissecting aneurism, an occurrence which is not altogether unfrequent, and is productive of such symptoms as the patient presented. The actual cause of obstruction, however, was somewhat different: it was the gradual encroachment of the clotting which was taking place in the lower of the two aneurisms on the channel of the adjoining portion of the aorta, and either its subsequent displacement or the rapid coagulation of blood in the narrow chink which the older clot had left. Paraplegic symptoms have generally been observed in these cases; but here the paraplegia was as extreme and as complete as it would have been had the lower part of the spinal cord been the seat of general softening. There was total loss of muscular power, total absence of sensation, complete abeyance of reflex excitability, and involuntary discharge of fæces and urine. Moreover, nutritive lesions had appeared rapidly. Some of the sores, which ultimately became sloughy, were no doubt due to the application of hot bottles; but this was not the explanation of the large sacral bedsore, which was already extensive at the time of admission, or only four days from the commencement of his illness. The alkaline, albuminous, and bloody urine soon becoming offensive, was, doubtless, due to early inflammation of the bladder, which, increasing in intensity up to the time of death, induced at that time partial gangrene.

In the second case, as in the first, I was inclined to attribute the aortic obstruction to the sudden formation of a dissecting aneurism, commencing probably in the aortic arch, a view which seemed to me confirmed in some degree by the development as the case went on of bronchial symptoms. I thought in fact they might be due to obstruction of the bronchial arteries by the clot accumulated between the internal and external walls of the artery. As a matter of fact, the case, pathologically, was almost identical with the last. In this, as in the other, paraplegia was a striking symptom. But here the loss of power and of sensation was incomplete, and incontinence of the evacuations was present, if at all, in only a very slight degree. But other phenomena of much interest were observed. In the first place, it will be recollected that the patient had an attack of diarrhœa on the morning of the day on which he was taken ill; that this recurred in association with much pain at the anus at the very moment when from other symptoms we have reason to suppose that the aorta became blocked; that pain at the anus, with discharge of blood, continued to be one of the features of the case up to the time of death; and, further, that marked inflammation of the mucous membrane of the rectum was discovered post-mortem. There can be no doubt, I think, that the pain and discharge of blood which occurred latterly, and the rectal inflammation, were due directly to the impeded circulation through the vessels of the part. Is it not probable, then, that the diarrhœal attack which attended the onset of his fatal illness, and probably that which occurred in the morning, may have been the immediate consequence of circulatory default? In the next place, total suppression of urine seems to have succeeded to the accident for some hours, and during the remainder of the patient's illness the urine continued scanty, and underwent some remarkable changes of quality. Three ounces were withdrawn from the bladder at the end of the first ten hours, none having been voided meanwhile. This was absolutely healthy. During the next twenty-four hours he passed a few ounces into the bed, and an ounce drawn off at the end of that time by the catheter contained three-fourths albumen, but no blood. Subsequently he passed on two occasions collectively about nine ounces and a half of urine, which was not only albuminous, but alkaline and offensive, and contained pus-cells and bacteria. It will be recollected that at the post-mortem examination no passage existed between the renal arteries and the aorta above the seat of obstruction, and that, therefore, any circulation of blood through the kidneys could only have been effected circuitously through vessels distributed to their capsules; that the kidneys were large and congested, and that the mucous membrane of the bladder presented ecchymoses. From a consideration of the above facts, it will be admitted, I think, at any rate as probable, that in consequence of the renal arterial obstruction temporary suppression of urine took place, and that which was first removed, and was healthy in quality, was the urine already contained in the urinary passages and receptacles at the time of the accident; that later, owing to the partial establishment of collateral circulation, the secretion of urine began to be re-established, but that this (as might have been expected) was loaded with albumen; and that later still vesical inflammation arising, as in the first case, the effects of that condition in rendering the urine alkaline, purulent, and offensive became superadded.

The third case I confess I did not understand until the rupture of the aneurism took place and caused a series of symptoms the meaning of which was unmistakable. I was not misled by the history (which originally, much more than as I have placed it before you, suggested affection of the bowels), into thinking that the patient was suffering from any form of bowel disease. But I halted between renal calculus, malignant disease, either of the kidney or in its neighbourhood, and aneurism of the aorta. And when latterly the urine became scanty, and contained blood, albumen, and uric-acid crystals, the renal interpretation of the case began to acquire predominance in my mind. I acknowledge, however, that a careful consideration of all the facts of the case, as detailed in my notes up to the time of rupture, especially if interpreted by the light thrown upon them by the other two cases, might probably have led me to an accurate diagnosis. It will be recollected, however, that no abdominal tumour had been detected by myself or by others who had examined the patient. The points of chief interest in this case are, that (as in the other two) obstruction of the aorta, and cessation of circulation in the parts below, were attended with paraplegic symptoms; and that (as in the last case) obstruction to the renal circulation caused almost complete suppression of urine, such urine as was secreted becoming at the same time highly albuminous. In this instance it presented granular and bloody casts. There was no absolute obstruction of either the aorta or of the large vessels springing from it in the neighbourhood of the aneurism at the post-mortem examination; but the accumulation of blood around them was quite sufficient to have caused obstruction by pressure or stretching. The fact that before death his lower limbs became absolutely pulseless and partly paralysed renders it certain that the aorta was actually obstructed; the fact that the left kidney was congested, and presented large so-called "infarcts" of recent development (such as are only caused by arterial obstruction), render it certain that the left renal artery was actually obstructed; and both together make it not improbable that there was more or less obstruction also of the right renal artery, and may be of the cœliac axis and superior mesenteric also.

In conclusion, Gentlemen, permit me to make a few observations which suggest themselves to me from the consideration of these and of other like cases. Sudden obstruction of the aorta appears to produce not only arrest of circulation in all those parts which derive their blood-supply from the arteries which are given off at and below the seat of obstruction, but to cause also paraplegic symptoms, such as loss of voluntary power, loss of sensation, loss of reflex action, and incontinence of urine and fæces, closely resembling those of paraplegia arising from direct disease of the cord, and which, like them, vary in their severity in different cases. To what are these symptoms to be attributed? I suspect that the explanation is twofold: that it is partly due to sudden arrest of those nutritive processes on which the preservation of vitality depends throughout the various tissues whose functions are impaired or lost; and that it is partly due to the fact that there is direct interference with the nutrition of the lower part of the cord from obstruction of the arteries furnished to the cord from the aorta below the seat of obstruction.

But it is clear also, if the aortic obstruction be above, or involve the renal and mesenteric arteries, as happened in the three cases which I have adduced, that the organs which these vessels supply should suffer in their nutrition and innervation, and consequently functionally, just as the skin and muscles suffer, and that special symptoms might hence

be looked for in connexion both with the intestines and with the urinary organs. My cases seem to show that it is so. Obstruction of the mesenteric arteries, though perhaps immediately inducing anæmia of the bowels, soon leads to congestion, stagnation of blood, inflammation, and gangrene. This seems to have actually occurred in my second case. Obstruction of the renal artery might also at first cause anæmia of the kidney; but soon through small collateral vessels blood finds its way into the organ, which becomes congested, and owing to impaired nutrition the seat of so-called "infarcts." That these phenomena were present, at any rate, in two of my cases seem certain. For suppression of urine in both cases followed the obstruction, and the urine which was subsequently passed was albuminous, and contained blood. Again, one would expect the bladder to suffer in the same way as the rectum, and from the same cause. In every case the bladder was actually inflamed, and the ammoniacal condition of the urine which supervened in two after a time was probably due to this circumstance.

I have referred in my comments on one of my cases to the supervention in their course of the nutritive lesions, which are apt to follow spinal disease, and suggested that the early appearance of bedsores and inflammation of the bladder might thus be explained. I need scarcely say, however, that here we have a complex problem to deal with, and that, although direct nervous influence may have had some effect in producing these conditions, it is at least as probable that they were due to arrested circulation and tendency to death of the parts.

Another matter to which I may refer is the duration of cases of aortic obstruction. It might be supposed that, as is warranted by the cases I have adduced, early death must in all cases ensue, and that anything like recovery would be impossible. That permanent recovery should take place is, of course, from the nature of the disease, impossible. But there is a tendency more or less pronounced for collateral circulation to be established, and thus for parts that were cold and moribund, to resume their normal state. That tendency for the re-establishment of circulation and the restoration of function was shown by my cases in respect of the kidneys by the tendency to the re-establishment of the urinary secretion which actually occurred. But it was shown even more plainly by the restoration of warmth to the upper part of the legs, and by the limitation of gangrene in one of them to the toes and other parts of the feet. But this reinstatement is sometimes complete. I recollect a case in point, which was put on record in the Pathological Transactions by Dr. Swayne some years ago, and impressed me very much. It was that of an elderly gentleman, who had sudden obstruction of the aorta in consequence of the formation of a dissecting aneurism, and who presented many of the symptoms which my cases also presented. The circulation became re-established by collateral channels, and he recovered so as to be able to drive about in his carriage. But he died of pulmonary complication at the end of three months.

The last points which I intend to bring under your notice concern the circulation. It was mentioned that in two of the cases the pulse was full and bounding, and felt much like that of aortic regurgitation. I bring the tracing from one; it was alike in both. In only one of the three cases was a murmur detected in the abdomen. It was observed at the apex of the epigastrium, and was prolonged feebly from that point for two or three inches downwards. It presented peculiarities, which I have observed before, and to which I have called students' attention. Murmurs at the cardiac orifices correspond either to the systole or to the diastole of the ventricles of the heart; a systolic murmur never being continued into the diastole, or conversely. And if, as not unfrequently happens, cardiac murmurs are heard in the course of the arteries, these murmurs, as the case may be, correspond also either to the cardiac systole or to its diastole. Now, in my case, as also is the case with many aneurismal murmurs, and, in fact, as one ought to expect, the murmur, commencing with the percussion wave, was continued not only through the whole duration of the tidal wave corresponding to the cardiac systole, but somewhat modified in character beyond even the aortic notch, and into that portion of the pulse which corresponds to the cardiac diastole. In other words, the murmur being due to the onward passage of blood, continues so long as the passage of blood is sufficiently rapid to evoke sound, and that does not necessarily cease when the cardiac systole ceases.

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FURTHER RESEARCHES ON

ETHYLATE OF SODIUM IN THE TREATMENT OF NÆVUS AND OTHER FORMS OF DISEASE,

WITH OBSERVATIONS ON ETHYLATE OF POTASSIUM.[1]

BY BENJAMIN WARD RICHARDSON, M.D., F.R.S.

THE introduction of sodium ethylate, like that of amyl nitrite, into the practice of medicine and surgery, was due to the researches on the amyls, ethyls, and alcohols, which I had the honour to carry out for my reports to the British Association for the Advancement of Science between the years 1863 and 1871. In observing the action of the more ordinary form of alcohol—the ethylic—on the blood and the tissues, it occurred to me to inquire what difference of action would occur if an alcohol was used in which sodium or potassium takes the place of the remaining atom of hydrogen which belongs to the water molecule present in the alcohols—that is to say, what would be the action of ethylic alcohol if the radical ethyl which replaces one of the hydrogens of the water was united with a metal like sodium or potassium, instead of hydrogen? The ethylates of sodium and potassium, sodium and potassium alcohols, were at that time well known as chemical substances; but they had not been used as medicinal agents, nor had their employment as remedies been suggested. It struck me, however, that they might come in as serviceable caustics, and at the same time as antiseptics.

To test their value in the last-named direction—I mean as antiseptics—I brought them into contact with fresh brain-substance taken from the newly-killed sheep, and found that they powerfully preserved the structure. I also noticed that when they were placed in contact with animal structures they were rapidly decomposed; they were oxidised. Soda or potash was produced, and absolute alcohol was reproduced. When the ethylate thus employed was a concentrated solution, or when it was used in the form of crystal, the effect of the produced alkali was to maintain the softness or the fluidity of the structure acted upon. When the ethylate was much diluted with alcohol the effect was different; then the alcohol acted as an agent for producing rapid coagulation of the albuminous or fibrinous substance. This observation, which at first sight may appear of minor moment, turns out to be of considerable importance when the details of practice, in connexion with the ethylates, are under consideration—a fact which will be better seen further on.

The result of my experimental inquiry was to indicate that in the ethylates of sodium or potassium we had a substance which, brought into contact with colloidal tissue, would be decomposed into an active caustic in the nascent state, and into alcohol which, in the same state and at the same time, became an antiseptic, a styptic, and a pectiniser, or producer of coagulation.

Extending the inquiry to newly-drawn blood, I learned that by concentration of the ethylates I could hold the blood fluid, while by diluting them with alcohol I could cause immediate and firm coagulation. I learned, moreover, that I could change the character of the red corpuscle in the most determinate manner; that the corpuscle could be made to pass into a complete crystalline form by a strong solution; while by dilution it could be simply shrunken into a very minute and contracted condition.

The facts ultimately led me to think of applying the ethylates to living tissues as a method for removing vascular growths. I reasoned that when an ethylate was applied to a vascular growth the metal—sodium or potassium—would be oxidised and become a powerful caustic, while at the same time the alcohol that was reformed would fix the destroyed matter and the blood by the process of coagulation, and would at the same time prevent decomposition.

The choice of sodium or potassium alcohol was now before me, and ultimately I selected the sodium as the best for all practical purposes of the ordinary kind. The reason for this selection was based on the following experience:—My friend, Mr. Lord of Hampstead, had a patient who was

[1] Read before the Medical Society of London, on Monday, Jan. 17th, 1881.

suffering from three large vascular growths on the scalp, and in consultation with him I proposed to destroy one of these growths by means of potassium ethylate. The suggestion was adopted, and the destruction of the growth for the time was effective. The hæmorrhage which occurred was, however, so profuse and was checked with so much difficulty, that I determined in treating the other tumours to use the sodium ethylate preferentially. This acted well, and the destruction of tissue was accomplished without any trouble from loss of blood. The growths, in the end, assumed the malignant character, and the patient sank from the extension of the disease. The experience of the difference of action of the two salts, in respect to bleeding in this case, led me to propose the sodium ethylate as the safest, if not the most active, compound. It was in the first part of these inquiries that I used the ethylate of sodium with so much success in the treatment of a case of intractable nævus that had been under the care of my friend Mr. Gay. Mr. Gay was good enough to place that patient entirely under my charge and the recovery was perfect. As the Society is aware, a good many years elapsed before the employment of the ethylate came again under professional notice, through the admirable paper read before the Society, on the Treatment of Nævus, by our able colleague, Dr. John Brunton. From one occupation or another, the clinical use of the ethylate had, except on special occasions, passed out of my thoughts, until Dr. Brunton's labours revived it. Since then I have been more attentive to it, and have gained some further experience, which may, I hope, be useful to relate.

In the treatment of vascular nævus (cutaneous) I have had since my last report nine cases, each of which has done well. They have all been in children, and some of them have been cases in which other modes of treatment had, previously, been tried. It may be well to give a brief review of these cases in order.

The first was an instance of the common form of nævus on the scalp in an infant three months old. After perfect recovery from vaccination, the treatment commenced in the usual way by the application of the ethylate over the growth, by means of the glass-rod. The nævus was small, not larger than a fair-sized hazel nut. The first application caused a dense scale to form, which was loose and removable on the fifth day. The ethylate was then reapplied, and five days later, when the new scale was removed, the nævus was reduced to the size of a small bean. It remained in this state during three further applications of the ethylate, being much longer under treatment than I had expected after the second application. On the seventh application it was nearly removed, and one additional touch a fortnight later completely removed it. No constitutional symptoms interfered with the course of the treatment, and no scar remained.

In the next example the treatment was almost identical both in respect to mode and to result; but as the patient was very restive and screamed extremely when the ethylate was applied, advantage was taken to make the application when the infant was in a deep sleep. The plan succeeded so well that I venture to suggest its general adoption in young children whenever the nævus is in a situation where it can be easily got at, and whenever an intelligent nurse or parent can be taught to make use of the solution in a safe and efficient manner. In the case in question the nævus was quite removed in the course of six weeks, and it can scarcely be said that any pain at all was inflicted. No scar has been left.

The third illustration was not so favourable as the two above named, although in the end the patient did well. The nævus, again on the scalp, was near to the anterior fontanelle, the fontanelle itself being large. A cerebral pulsation, distinctly marked, extended to the nævus itself. I judged at first that there was a communication from the external nævus to another vascular enlargement within the cranial arch, but this turned out to be incorrect. The child was eight months old, was pale and feeble, with a large head. The nævus originally was of the size of a small walnut, and very prominent. The first application of the ethylate gave rise to a large and firm scale of the usual kind, which was removable on the fifth day. The second application caused a great deal of pain, and the crust which formed remained for a week immovable. When the crust was at last loosened and lifted up, the nævus was found to be reduced in size, but excessively red and vascular. It was freely treated with the ethylate, and again a dense and firm crust resulted. Four days after this the crust was quite firm, and on the eighth day, as the crust was still immovable by the ordinary method of lifting it up with forceps, I, forgetful for the moment of my own instructions, directed the nurse to apply a poultice and bring the patient to me again when the crust was softened. Two days later the child was brought very unwell. It was feverish; temperature 103°. There was an odour of decomposition from the nævus, and a dark sphacelus. I immediately dried the part most carefully with absorbent wool, and applied ethylate freely, covering with dry wool lightly. The good effect was immediate; the decomposition was arrested, a new and firm crust was formed, and from that time the recovery went on favourably, the nævus being destroyed, and scarcely a scar being left. The error I made in this instance consisted in the use of moisture from the poultice. It was this which set up the decomposition, and it was the decomposition and the secondary absorption which set up the febrile condition. I name the fact, and the temporary blunder involved in it, in order to re-enforce the point of practice that in using the ethylate water must never, under any pretence, be introduced as an adjunct. The mention of that example leads me to name the further practical suggestion that the removal of the crust, or the attempt to remove it too quickly, is not a good plan. It is best to let the crust come away of itself, or, at all events, to become so loose that it can easily be lifted away. We may take it as a general rule that so long as the crust is firm the nævus is contracting. Now, therefore, instead of removing the crust entirely, I am content to take off those parts only which are loose, and then to apply another touch of ethylate over the parts that have been removed. Certainly, all violence in removal is essentially mischievous. It causes pain; it often causes bleeding; and it prolongs, instead of expediting, recovery. When the crust is depressed in the centre it may be pierced with a needle, and a little ethylate may be introduced through the openings. This plan answers excedingly well.

The next four succeeding instances of nævus treated with the ethylate presented no special features, except that in one of them there were two growths on the same patient. The question here was raised, whether it was best to treat both the tumours at the same time, or one at a time. The last-named course was adopted, and with very good results. The nævus first subjected to treatment was removed in twenty-four days, and after a week the other one, which was smaller, was removed in a little less than the same period of time. The four cases did well, and in one only is there any appreciable scar. The patients were all young. The youngest was six months; the eldest a little under two years of age.

I now come to two cases in which the treatment with the ethylate, though successful, was not so facile. The first of these instances was sent to me by my friend Dr. Stevens, of Norfolk-crescent, Hyde-park. The patient was a beautiful little girl in her second year, and the nævus was situated over the left eye involving the lid. The nævus was of the dimension of a fair-sized strawberry, and various attempts had been made to remove it without success. I commenced in this case by applying the ethylate very freely to a lesser portion, or, I had almost said, segment of the growth, for it was, to a certain extent, divided into two parts. When a fair crust was established on the part treated I applied the ethylate to the remaining part. After four applications I succeeded in getting the whole mass under a firm encrustation, and from the beginning to the end of the treatment, which lasted seven weeks, I forbore from ever forcibly raising the encrustation. Whenever I found a portion of the crust quite loose I lifted it away and reapplied the solution. In this manner the nævus was destroyed, and although a little trouble was for a few weeks experienced with one small remaining spot, in the end the cure was complete, and I had the satisfaction of hearing a few weeks since from the father of the patient that the eyebrow was appearing, that there was no scar, and that some remaining redness, which I had feared might be permanent, was passing away, so that the parts were assuming a perfectly natural colour. The size of the nævus in this case and its position over the eyeball made the treatment more than usually troublesome; but the result was a fair reward for all the pains that were bestowed. The chief difficulty consisted in applying the solution in such a manner as to prevent it from affecting the eyeball itself. Once, during a short and determined struggle by the little patient, a small portion of the solution did touch the conjunctiva, but I removed it instantly by a pouch of cotton-wool, and no mischief followed.

The last case of nævus to which I have to refer was in an infant about ten months old. The nævus was in the fore-part of the neck, and immediately over the larynx. It was of the size of a half-crown piece, and not much raised. It was troublesome to treat on account of two complications. In the first place, after the vascular structure seemed to have been entirely destroyed, it reappeared in small points not larger than the head of a pin. In the second place, whenever the ethylate was freely used, so as to destroy a large surface of the growth, a very peculiar, sharp, croupy cough was set up, which indicated the necessity of limiting the application. These obstructions, combined with the desire not to produce a scar, caused the treatment to be very prolonged, and to extend over several weeks. Fortunately it has, I hope, ended successfully, and I apprehend without leaving evidence of scar, though that remains to be proved.

(To be concluded.)

SIX CASES OF PARACENTESIS THORACIS.

BY A. W. MAYO ROBSON, F.R.C.S.,
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SINCE the subject of paracentesis thoracis in pleurisy with effusion has been thought worthy of being discussed lately by the Medical Society of London, the following cases I venture to hope may prove sufficiently interesting for publication, especially as they bear on the possibility of cure by once tapping, and on the danger of rapidly drawing off a large volume of fluid at one operation. Moreover, the cases have not been selected, but are reported as they occurred, being the only pleuritic effusions which I have had to treat in my own practice during the last two years.

CASE 1.—Mr. C——, aged thirty-two, with a phthisical family history, consulted me, saying that he had been well up to three weeks before, when he began to suffer from a "stitch" in the left side, that he was now very short of breath, and had difficulty in ascending a hill; his appetite had become impaired, and he was losing flesh rapidly. I found the left side dull as high as the inferior angle of the scapula, with an absence of breath sounds and vocal fremitus, but there was no disease of the lungs or other viscera. I ordered a blister to the side, and gave digitalis and iodide of potassium, but after a fortnight the fluid had reached the spine of the scapula. I advised a dry diet, and that as little fluid as possible should be taken, at the same time giving small doses of elaterium. For a few days the fluid diminished a little, but after a week it remained stationary, and my patient became tired of his rigid diet. I advised paracentesis, but, before operating, asked Dr. Clifford Allbutt to see the case with me. He fully endorsed my recommendation.

By means of the aspirator I drew off two pints and a half of clear straw-coloured fluid through the eighth intercostal space. My patient was at once relieved, and forthwith began to improve. Although a little fluid collected again during the next ten days, under the use of an iodine liniment externally and iodide of iron internally it became absorbed; and at the end of five weeks he went to Torquay for change of air. On returning a month afterwards he had gained 10 lb. in weight, and the lung seemed to have fully regained itself.

CASE 2.—Mrs. K——, aged thirty, with a family history of phthisis, told me that she had caught cold two weeks previously, and had been suffering from pain at the side and shortness of breath ever since. She had lost flesh and was looking distressed and haggard. The right side was dull up to the fifth rib, and presented the usual signs of fluid in the pleura.

A blister was applied to the side and digitalis, iodide of potassium, &c., were given, but the fluid still increasing, the dry diet treatment was adopted. No improvement resulting, tapping was advised, but as the patient and her friends said that she should not undergo an operation if it could be avoided, medicinal treatment and iodine externally were tried for several weeks, at the end of which time the dulness had reached to the clavicle, and the heart was pushed to the left; the pulse was small and intermittent, the lips were livid, and the patient had to be constantly sitting up in bed in order to breathe. At last she consented, and I drew off by means of the aspirator four pints and a few ounces of a clear straw-coloured fluid. The pulse at once became fuller, more regular, and slower, the heart assumed its normal position, the lividity disappeared, and she could bear to lie in the recumbent posture. Vesicular breathing could now be heard in the infra-clavicular region, but not below. Although her condition improved daily, some fluid returned, and a fortnight afterwards the dulness reached the mammary line; however, under the use of iodine externally and iodide of iron internally it gradually disappeared, and six weeks after the operation she was able to go into the country for change of air, there being a little dulness and some falling in of the right thoracic wall. After being eight weeks in the country she called on me, and I found she had gained 9 lb. in weight There was vesicular breathing all over the right side, and but for the slight falling in opposite the eighth, ninth, tenth, and eleventh ribs, no evidence was left of her attack.

CASE 3.—The above patient, Mrs. K——, continued quite well for fifteen months, when she caught cold, was seized with pain in the left side, and was in every respect similarly affected as she had been in the previous attack, excepting that she could now only bear to be on the right (sound) side. Effusion came on very rapidly, so that a week after hearing a friction sound over the front of the chest the dulness had advanced as high as the clavicle, and the heart had become slightly displaced to the right; the distress in breathing, though severe, was not so great as when the effusion was on the right side. She begged to be tapped, and I at once drew off by means of the aspirator and a large needle five pints of clear fluid. She was seized with a violent fit of coughing before the needle was withdrawn, became livid in the face, and breathed with great difficulty; for a few minutes I was very anxious, as the pulse was small and fluttering, and she seemed to be in great distress. I gave one-sixth of a grain of morphia by injection, which soon relieved her. From this time she had not a bad symptom, was out of bed in a fortnight, and able to leave for the country in a month. Two months afterwards she called to see me, and appeared to be in very good health; both lungs were doing good work, and the left side of the chest had not become depressed in the least.

CASE 4.—A. B——, aged thirty-six, got wet through, shivered and felt a pain in the right side; the temperature reached 102·6° and 103° for several days in succession, and there were the physical signs of pneumonia of the right lower lobe. A distinct crisis never occurred, the temperature for nearly a month rising each evening to 100° and 101°, and night sweats coming on. At the end of a month the dulness still continued, but as vocal fremitus had disappeared and he could only bear to lie on the sound side, I feared an empyema was forming, and explored by means of the aspirator. Finding the fluid clear, I drew off a pint and a half, giving my patient great relief. Some fluid returned, and at the end of three weeks I again drew off a pint, and in a fortnight three-quarters of a pint more, after which recovery was steady but sure, and he was well in three months from the commencement of his illness.

CASE 5.—Mrs. H——, aged twenty-seven, with a family history of phthisis, became debilitated by suckling, and caught cold. She called to consult me for a pain in the side which had existed for a fortnight, and for shortness of breath. On examination I found signs of fluid in the left pleura as high as the fifth rib. After twelve days' medical treatment, there being no improvement, but rather an increase of the effusion, I drew off a pint and three-quarters of clear straw-coloured fluid. She was at once relieved. After a few days a little fluid returned, but under the administration of iodide of iron and cod-liver oil, with the external use of iodine, it gradually disappeared, and she was able to go out in a month. Some dulness, evidently due to thickened pleura, remained for some time, and the lung expanded slowly, but at the end of three months (she having in the meantime spent a month at the seaside) I found the lungs doing good work, and the dulness scarcely perceptible.

CASE 6.—Miss M——, aged twenty-one, called to consult me, saying she had been ailing for several months, but that during the last few weeks she had been suffering from pain in the side and shortness of breath. She had lost flesh considerably. On examination, I found the left side of the chest dull up to the spine of the scapula, with the usual signs of fluid. As the temperature was 101°, I advised rest in bed and poultices to the side, and gave ammonia and chinchona internally; the fever subsiding in four days, she was ordered to take iodide of potassium with the bark

mixture. At the end of ten days, there being no further improvement, but a slight increase of the fluid, I aspirated the chest in the sixth intercostal space, and took away two pints of clear fluid. My patient was at once relieved, and able to lie in the recumbent posture, she having been only able previously to be semi-recumbent and inclined to the right side. She improved rapidly under iodide of iron, with the external application of iodine liniment, was up in six days, and able to go out a fortnight after the tapping, feeling quite well in every respect, the lung having fully expanded, and very slight dulness remaining.

From the foregoing cases, and from others which I have observed in hospital and in private practice, I am as fully convinced that paracentesis thoracis, properly performed, is the best treatment in pleurisy with effusion, if the fluid be in any quantity, as I am that the administration of medicine to cause absorption is for the most part only waste of time to the doctor and disappointing and dangerous to the patient; for every additional day during which the lung is exposed to pressure, and time is allowed for cells to multiply in the fluid, lessens the chance of a complete cure, tends to permanently impair the lung, and to give rise to empyema with all its dangers; besides which, where there is extensive effusion there is more or less interference with the action of the heart, and great danger of sudden death.

Leeds.

SOME REMARKS ON THE TYPES OF PNEUMONIA WHICH ARE MET WITH IN NORTHERN INDIA AND IN NORTH-WESTERN AFGHANISTAN, ETC.

By C. P. COSTELLO,
SURGEON-MAJOR, BENGAL MEDICAL DEPARTMENT.

As regards the northern and north-western parts of India these remarks are founded on twenty-one years' experience, and are offered to the profession solely because many of the facts are not as generally known as could be wished, and are therefore likely to be of use to practitioners whose lot may be cast in India, and to whom, on first commencing practice there, some knowledge of the peculiarities of pneumonia as found in Northern India may be useful.

As generally met with, this disease both in Northern India and in Northern and Western Afghanistan presents an asthenic type, and is often "latent." Persons who have suffered much from intermittent fever are, as a rule, more liable to pneumonia than others, and, on this account, there may be a "malarious" cause in such cases; it may also be added that just at the end of the fever season, before intermittent fever has ceased to fill the hospitals—that is, about the latter part of September and in October—this disease becomes very prevalent indeed. As usually seen, it runs through the first and second stages pretty regularly, but rusty sputa are not always found, and often the stethoscope detects the disease when there has been no cough or expectoration, pain in chest, &c.; it is then, of course, "latent," and this, as a complication, is most usually met with in "remittent fever," or in enteric fever, &c. When not "latent," it does not always commence at the base of the lung and travel upwards, but often begins in the middle of the lung, or perhaps at the apex, although the latter is rare. Frequently it does not pass beyond the first stage. "Latent" pneumonia is, as a rule, found to be in the second stage when first observed; this may be, and probably is, due to the delay which occurs before it is observed. Pleurisy, to some extent, is not an uncommon accompaniment of the disease, and it has often occurred to me that the case under treatment might be correctly named pleuro-pneumonia. At first I expected that this pleuro-pneumonia was contagious, and, acting on the idea, I made it a rule to isolate all such cases. In 1875 an event happened which confirmed me in this idea as to the contagiousness of some forms of pneumonia, and especially, and almost always, of pleuro-pneumonia. This was when I had charge of the 1st Punjaub Infantry at Dera Ghazi Khan, and before proceeding further, I should state that pleuro-pneumonia was very fatal amongst cattle in the Punjaub, and in the north-western frontier districts—more markedly in the lower Derajat—in that year. The 1st Punjaub Infantry, on being relieved by the 5th Punjaub Infantry at Abbotabad, marched through many of the affected districts to Dera Ghazi Khan; and the latter regiment, which took the same course to Abbotabad, had an identical outbreak, with even more fatal results, with that which I have now to describe as having occurred in the former. On joining the 1st Punjaub Infantry at Dera Ghazi Khan towards the end of March in 1875, the regiment was in a state of consternation at the number of deaths which had within a short time prior to my arrival occurred from "pneumonia." It was then rather warm at Dera Ghazi Khan, and there was not much variation of temperature in the twenty-four hours, or much difference between the day and night temperature, which made the continuance of the disease all the more inexplicable. At least from thirty to forty men had died from it in a few weeks out of a strength of about 550—as well as I can now without my notes recollect. On inquiry into the particulars &c., of the outbreak, I found them rather peculiar—viz., it was confined, almost, to two companies; when it began in the married lines, it spread from one to another of each family; in the hospital other patients not previously affected took it; and even the hospital servants, including a hospital assistant, got it apparently from patients suffering from it on whom they were, at the time of becoming ill, attending. It spread quickly through each lung, and from one lung to the other; there was scarcely ever a second stage, as the disease ran from the first stage quickly into the third, and into gangrene of the lungs. In most cases the nervous system was from the outset prostrated; the tongue dry, brown, and hard, there were sordes about the teeth, and in fact all the usual symptoms called "typhoid;" and there was in each case a "catching" pain in one or both sides—generally in a line under the axilla. I commenced by having the regiment removed from their barracks to tents; all persons affected with the disease were removed to a separate camp, where they were isolated from all others except their attendants; the attendants were forbidden from all communication with other persons or cases; and the barracks, married lines, &c., were thoroughly disinfected. Besides, everything was made ready for a march from the station should the outbreak not disappear with the above precautions. Soon after—almost at once—the above measures were taken the outbreak ceased, no new cases occurring, and within a fortnight there was not a case of the disease in the regiment. The 5th Punjaub Infantry at Abbotabad lost, I believe, sixty men from a similar outbreak; and although it was attributed to the sudden change from the warm climate of Dera Ghazi Khan to the cold and hilly climate of Abbotabad, I think that the cause was the same in both regiments—i.e., infection caught when marching through districts known to be affected with the cattle plague—pleuro-pneumonia—as met with in the year 1875 in the Punjaub and north-west frontier districts. The 1st Punjaub Infantry being chiefly "Pathans," had a great objection to post-mortem examinations, but I have had frequent opportunities in gaols under my charge on the north-west frontier of examining fatal cases of pleuro-pneumonia, and the appearances in the lungs were pretty uniform—viz., almost complete disorganisation of each lung with numerous and separate abscesses, and often gangrene of parts of the lung affected. Both lungs were usually involved, and there was a good deal of dirty soft lymph on the pleura of the affected lung, with a sanguineo-serous fluid in small quantities in the cavity of the pleura. The blood found in the left cavities of the heart was generally dark and thin.

In the type of pleuro-pneumonia just noted I found that the most successful treatment was that which in erysipelas is found most effectual—i.e. quinine, chlorate of potash, and tincture of the sesquichloride of iron, in fifteen-minim doses, along with, in this case, expectorants, antispasmodics, &c. Stimulants and good nourishment were given from the outset, and with success. In the ordinary form of pneumonia, as met with in our part of India, &c., I find quinine in small doses combined with Dover's powder (one to two grains) and ipecacuanha the best internal remedies to begin with, combined with sinapisms, followed up by "jacket" linseed-meal poultices. Good nourishment has to be given from the outset. Very soon it is generally necessary to give ammonia, squills, quinine, and compound tincture of camphor, instead of the Dover's powder, quinine, &c., above mentioned, and port wine or brandy has to be ad-

ministered more or less freely, according to the tongue and pulse. I have never met with a case of pneumonia in Northern India which was benefited by bloodletting in any form, although I used to employ leeching and cupping in my earlier treatment, and so had then sufficient experience of the injurious and sometimes fatal effects of such treatment. As far as I have seen, the above remarks regarding the symptoms and treatment of pneumonia apply to Northern and Western Afghanistan, in both of which I have served, and as much to Europeans as to natives of the country, with this exception, that stimulants can with Europeans be begun earlier and have to be given more freely, as a rule, than with natives. A routine administration of either medicines or stimulants is, of course, to be deprecated in all cases, especially as it sometimes happens that wine or spirits, when given without attention to the pulse, increase the inflammation of the lung.

Jagdallack Kotal.

CASE OF TRAUMATIC TETANUS TREATED WITH CALABAR BEAN; RECOVERY.

BY C. CLARK BURMAN, L.R.C.P. & S. ED.

ON Sept. 8th last I was called to see a boy, eleven years of age, who had received an injury to his foot whilst driving a reaping machine. On examination of the case I found an extensive lacerated wound of the left heel; a large flap of skin and subcutaneous tissue was reflected over the os calcis, laying bare the posterior, and part of the inferior surface of that bone, but not injuring its periosteum. The tendo Achillis was laid bare for about two inches from its insertion to the os calcis. A considerable portion of the flap was missing upon its inner side, and its only connexion to the sole of the foot was by a narrow strip of skin, not more than half an inch in width. After cleansing the wound I replaced the flap, and retained it in position by means of sutures; but, as I feared would be the result, the upper and outer part sloughed—due, no doubt, to the small vascular supply through the narrow neck connecting it to the uninjured skin. Otherwise the wound was progressing favourably; the boy was in good spirits, and complained of no pain, except during the dressing of the wound. At first cold-water dressings were used, but so soon as sloughing took place carbolic-acid lotion was substituted. Upon Friday the 17th it seems that he complained to his mother of a "stiff neck," but of so slight a nature as not to be mentioned to me upon my visit next day. On Sunday the 19th he complained of stiffness of the jaws and difficulty in mastication, which on the following day had developed into well-marked trismus, the sterno-mastoid muscles upon each side being in a condition of tonic spasm. The risus sardonicus was distinct; the teeth could be separated only about half an inch; no general convulsions, however, had been noticed; there was great nervous excitability and slight epigastric pain. The pulse was 120 and hard, as if the arterial coats sympathised with the general muscular contraction. I at once prescribed chloral hydrate and belladonna in full doses, kept the room darkened and quiet, ordered him milk and strong beef-tea, with small but frequent quantities of port wine. An enema of castor oil and turpentine was administered. Upon Tuesday, the 21st, the first convulsion appeared, which was, however, neither severe nor of long duration. The pulse was still rapid and hard, but accompanied with very little feverishness. The wound was doing well, the slough separating nicely. During the two following days his condition was much the same, a general spasm occurring upon any sudden start or exertion, such as moving to have the wound dressed, &c. To relieve pains that he experienced along the upper part of his spine, he was laid upon his abdomen, with a pillow under his breast, and in this position he remained until convalescent. Ice not being readily obtainable, I ordered india-rubber bags filled with cold water (frequently changed) to be kept constantly applied to the lower cervical and upper dorsal regions.

Considerable difficulty now began to be experienced in swallowing the chloral and belladonna mixture, almost every attempt producing a convulsion, in which the body assumed the characteristic arched position, and all the muscles became quite rigid. He was able, however, to take considerable quantities of milk, also wine well diluted. I now administered morphia hypodermically, but the nervous excitability had now reached such a pitch that even to do this produced a convulsion. The jaws being now almost completely closed, and the difficulty and danger of administering remedies had become so much increased, that I obtained from Messrs. Savory and Moore a supply of their gelatine lamels, containing one-sixtieth of a grain of extract of Calabar bean in each; and on Wednesday, the 29th, I prescribed one every four hours, continuing the stimulants and as much milk and beef-tea as could be taken. The lamels were slipped in between the teeth and allowed to dissolve in the mouth. On Sunday, the 3rd October, decided symptoms of improvement showed themselves; the convulsions, which a few days before were so frequent and so easily excited—even the sudden falling of the door-latch was sufficient to induce one—were now less frequent and not so severe. The jaws could be opened to a slight extent, and the boy could retain and swallow his saliva. The general improvement continued until, on Thursday, the 7th, he was able to take a little boiled bread and milk, only one or two convulsions having occurred since the 3rd. The lamels were continued until October 10th, and since then his progress towards recovery has been steady and uninterrupted.

Throughout the whole progress of the case the state of the wound was all that could be desired; the slough having separated it was granulating nicely, no pain or uneasiness being experienced. On my last visit (Oct. 25th) he was sitting up, dressed, and able to get about with the assistance of a crutch, the only drawback being a little stiffness of the ankle from prolonged rest, which, however, readily gave way under passive motion; and a few days ago I had the satisfaction of seeing my patient walking about, looking little the worse for the severe illness he had gone through.

Whether the recovery of my patient was due to his youth, good health, and ability to take so much milk, beef-tea, &c.—thus keeping up his strength and enabling him to live out the disease, or to the use of the Calabar bean, or both combined—is, of course, a moot question, but the marked, immediate, steady improvement that took place after the administration of the Calabar bean would seem to indicate that that drug played a serviceable and important part in the treatment of the case, as also to show cause for a further trial of the Calabar bean (in the form of gelatine lamels) in similar cases.

I must speak a word of praise on behalf of the gelatine lamels. Their portability is evident, but I scarcely think their usefulness, under the circumstances as above described, is sufficiently appreciated. It is usual to administer remedies for tetanus hypodermically, but, as I have stated, this simple operation in my patient, whose nervous system was in so excited a condition, proved objectionable, on account of its bringing about a condition of tonic spasm, which it was sought to avoid or prevent. On the other hand, the administration of *fluid* remedies by the mouth, even when available, as in the early part of the disease, is not without similar dangers, inasmuch as in this case it proved so irritating that a choking fit, culminating in a general convulsion, almost always followed the attempt to swallow them; whereas the lamels, having been slipped between the closed teeth, were slowly dissolved and absorbed without causing any spasm.

Belford, Northumberland.

THE INTERNATIONAL MEDICAL AND SANITARY EXHIBITION.—At the meeting of the Executive Committee, held on Wednesday last, Mr. T. Greenish, the President of the Pharmaceutical Society, Mr. James Cantlie, F.R.C.S., of Charing-cross Hospital, and Mr. Edmund Owen, F.R.C.S., of St. Mary's Hospital, were elected members of the committee. The guarantee fund has been increased by more than £100 in the last week, and Sir James Paget has placed his name upon the list of guarantors for £10 10s. The forms of applications for space are being prepared, and will be forwarded as soon as ready to those applying for them. No application for space will be considered unless received by the last day in March. Means are being taken to advertise the Exhibition in France, Germany, Austria, Italy, Russia, Scandinavia, Canada, the United States, India, and Australia.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium

EAST LONDON HOSPITAL FOR CHILDREN.

CASES OF CONGENITAL SYPHILIS.

(Under the care of Dr. FRANCIS WARNER.)

THE following cases illustrate the occurrence of temporary enlargement of the spleen and of laryngitis in syphilitic infants.

CASE 1. *Spleen enlarging under observation; desquamation of skin.*—Ada B——, aged nine weeks, was seen as an out-patient on June 4th, 1879, on account of a rash on the skin, and running from the eyes and nose. She had appeared healthy at birth. When five weeks old little red patches appeared first on the feet; the skin then turned white, and blisters formed and broke, and the feet had never been healthy since. Similar spots appeared on the face, and the rash gradually spread to the whole body. As the latest development of the skin disease, the nates had become very sore a fortnight previously.

When seen there was very marked desquamation of the hands and feet; the child snuffled, and there was a thick yellowish discharge from the nose; no thrush and no disease of the nails; no thickening of the long bones of the skull; voice in crying fair; spleen and liver not enlarged. Ordered twenty drops of solution of perchloride of mercury, with a little iodide of potassium, three times a day. A week later it was noticed that she looked better, the skin healing, with less desquamation.

On June 19th the sores on nates had healed; there was less desquamation. Spleen now felt distinctly enlarged, extending almost up to the umbilicus; the enlargement had occurred under observation. The child was stronger and better. There were no signs of rickets.

The skin condition continued to improve. The spleen was very distinct. On July 9th the spleen was subsiding; rash gone; no desquamation; still discharge from nose. On the 17th the spleen could not be felt enlarged; the child was getting fat. On Oct. 9th there were no visible signs of syphilis, and on Dec. 18th the child was healthy-looking, fat, and well.

CASE 2. *Child voiceless; laryngeal disease; death; necropsy; large spleen.*—Florence T——, aged seven weeks, was seen as an out-patient on Nov. 28th, 1878. When born there were "bladders full of water" about its head, but otherwise she appeared healthy. At three weeks old she had a sore mouth and face with thrush. When first seen the voice was fair; there was disease of the nail of the first finger of the left hand; it was dry, hard, and dead; the mother said there had been a little matter under it, but there was none seen. No other nail was thus affected.

On December 5th, on crying, the voice was lost, or almost lost. Much staining of the skin around the mouth, and on the nates and around the anus there were abrasions and dark-stained patches; no sores between the fingers and toes; thrush in mouth; spleen and liver appeared normal. It was found that soreness of the nates appeared with thrush when the child was three weeks old.

On the 17th there were fissures at angles of mouth and eyelids; the skin of forehead was desquamating; some desquamation of legs. Desquamation had occurred where there had been redness; thrush had gone. She was made an in-patient, and died Dec. 25th.

At the necropsy on Dec. 26th, brain, meninges, and skull were normal; the lungs were the seat of lobar and lobular pneumonia; the liver and kidneys were healthy; the spleen was large, and had recent lymph on its surface, causing soft adhesions; no other peritonitis. Larynx presented marked signs of disease, showing an ulcerated surface with a papillomatous appearance both above and below the ventricles; bronchi healthy.

The mother was under treatment for constitutional syphilis, with ulceration of the tongue and laryngitis.

CASE 3. *Voice hoarse; condylomata; ulcers on tonsils; nasal discharge.*—Henry G——, aged ten years, was first seen on Oct. 16th, 1879. His voice was hoarse; this was said to be recent. Around the anus were large condylomata with ulceration; these had appeared about three weeks previously. Ulceration of both tonsils had existed two months, and there had been discharge from the nose five months. The bowels were costive, and defecation was often attended with bleeding. There seemed no doubt that the boy was syphilitic, but on the other hand there was no proof that the syphilis was inherited, nor any suspicion that it was accidentally acquired. There was no keratitis, no ophthalmoscopic changes, no bone thickening, and no deformity of head or nose. On inspecting the throat there was seen superficial ulceration of either tonsil, spreading to the uvula and soft palate. From the nose there came an unhealthy glairy discharge, causing excoriation. Hoarseness of the voice was marked, and attended with marked stridor on deep inspiration. Ordered thirty drops of solution of perchloride of mercury, subsequently increased to sixty drops, with iodide of potassium, four times a day. The condylomata soon became drier; the tonsils, larynx, and nose remained diseased much longer. Tonsils were noted as healed on Nov. 13th. At that time an ulcer was seen over the right arytenoid cartilage. On Dec. 4th the ulcers on tonsils had healed; nostrils did not discharge; the latter symptom, however, returned. The condylomata healed up, but reappeared in January. Finally, by February the throat and nose appeared healthy, and the laryngoscope showed no ulcers, but the voice was still hoarse.

The patient was the youngest of eleven births:—1, never healthy, died at twenty-one years; 2, girl, died at twenty-four years, weakly; 3, girl, died at twenty-two years, weakly; 4, stillborn, healthy; 5, twins, one wasted, other stillborn; 6, stillborn at full term; 7, stillborn at full term; 8, miscarriage at fourth month; 9, stillborn at full term; 10, boy, aged twenty years; 11, patient. The patient was considered healthy at birth, and never had any sores on the skin till October, 1879. There was no history, sign, or probability of infection of syphilis.

CASE 4. *Spleen large, subsiding; slight rickets.*—Thomas D——, aged nine months, was seen as an out-patient June 12th, 1879. The mother said he had been healthy and well the first three weeks after birth, but not very fat. Then a rash came out on the nates, legs, and feet. "Blisters came out and bled"; these died away in a fortnight, and nothing more appeared till two months ago. There was thrush at the same time as the rash. Patient was the first child; there had been no miscarriage. The mother had some rash on her body while pregnant. When seen there was thrush; brownish mottling of the face, especially on forehead. In the right temporal region an oval patch, dark-brown, smooth and dry edges, slightly raised; a similar patch on chin. An abrasion, the size of a threepenny-piece, was seen at the side of the anus. There was moderate rickety condition, with "beading" of the ribs. Fingers and nails healthy; no bone thickening discovered. Spleen large, distinctly felt. Glands in both Scarpa's triangles enlarged. Ordered mercury ointment to be rubbed in.

On the 27th the ulcer near anus was not healed, and there was much discharge from nose. Voice good. Ordered twenty drops of solution of perchloride of mercury, with iodide of potassium, four times a day.

On July 10th two grains of mercury and chalk powder given four times a day. On the 24th the ulcers were healing. Spleen still large. Very little discharge from nose; not getting fat. On Aug. 14th no rash; the child appeared healthy and well; fat. Voice good; spleen subsiding. On Sept. 2nd the spleen could not be felt. No running at nose. On Jan. 5th, 1880, the child was well and fat and had no sores.

Remarks.—These cases illustrate the occurrence of temporary enlargement of the spleen, of chronic laryngitis in syphilitic infants. As to the splenic disease, in Case 1 the enlargement of the spleen occurred under observation, and lasted about one month. It appeared as the exanthem was passing off. In Case 2 the enlarged spleen was found on autopsy, and was covered with recent lymph. In Case 4 the spleen was enlarged during the exanthematous period, and subsided under observation. The child was slightly rickety, and this might be supposed to be the origin of the splenic enlargement, but that the subsidence was more rapid than

occurs in rickets. With regard to the laryngitis, in Case 2 the child was voiceless, and the laryngeal disease was seen after death. In Case 3 ulceration of the larynx was seen with the laryngoscope.

ROYAL BERKS HOSPITAL, READING.

SIX CASES OF OVARIOTOMY.

(Under the care of Mr. O. C. MAURICE.)

FOR the following notes we are indebted to Mr. C. R. Graham, house-surgeon.

CASE 1. *Antiseptic ovariotomy; rapid recovery.*—Elizabeth F——, aged forty-five, married, was admitted on December 6th, 1877. She had been in the hospital on several occasions, suffering from menorrhagia, with some uterine enlargement, but had never been actually incapacitated from following her household duties.

On admission she had a considerable tumour in the abdomen. There was fluctuation as well as dulness on percussion over the upper part of the abdomen, but the flanks were distinctly resonant. Measurements indicated an ovarian tumour. In order to verify the diagnosis the aspirator was used, and a small quantity of fluid drawn off.

On Dec. 23rd ovariotomy was performed antiseptically, the pedicle being ligatured. The case progressed so favourably that the patient was convalescent at the end of three weeks, and was discharged cured thirty days after the operation. The temperature on the morning of the 25th Dec. was normal, but rose to 102·2° in the evening, after which it gradually descended to normal. The pulse only once reached 105, that also being on the second day after the operation; it afterwards did not exceed 90.

CASE 2. *Antiseptic ovariotomy; recovery.*—Jane W——, aged forty-two, was admitted on Dec. 31st, 1878. She was married, and had had eight children, the youngest being born in February, 1876. The catamenia had been quite regular up to the time of admission. In February, 1878, she noticed a swelling on the left side about the size of an orange; it gradually got larger, but was not accompanied by much pain. Six months before admission ascites appeared, and continued to increase, giving rise to dyspnœa and great distress.

On Jan. 10th, 1879, paracentesis abdominis was performed, and nineteen pints and a half of ascitic fluid were drawn off, to the great relief of the patient. A hard, globular mass, about the size of the fœtal head, freely movable, could then easily be felt in the left lumbar region. An ovarian tumour was diagnosed, and on Jan. 23rd ovariotomy was performed under the spray. An incision four inches long was made in the mesial line. There were no adhesions; the cyst, which was multilocular, was tapped, and a small quantity of clear fluid and gelatinous matter were drawn off. The pedicle was secured by an ordinary double ligature, cut short, and returned into the cavity of the abdomen. The wound was brought together by deep silk and superficial wire sutures, and dressed with lint soaked in carbolic oil. Strapping, pads, and a binder completed the dressings.

On the 28th the dressings were removed, the wound looking well. Temperature 100°.

Two days later the four deep sutures were removed. A drop of pus escaped on taking out the lower one. Carbolic oil dressings were discontinued, the wound being simply strapped together with adhesive plaster and covered with oakum. Temperature 100·2°.

On Feb. 3rd the wound was dressed. With the exception of about half an inch at the lower part it was quite healed. Temperature 99·2°.

From this time the patient made a good recovery, although convalescence was somewhat delayed owing to the patient getting a small bedsore. She was discharged on April 1st.

CASE 3. *Dermoid cyst of ovary; ovariotomy; death.*—Jane P——, aged fifteen, was admitted on April 22nd, 1879. She gave the following history. About Christmas, 1878, she noticed a swelling on the left side of the abdomen, which gradually enlarged. It was occasionally painful. She admitted having had undue familiarity with her cousin, a lad of seventeen, six months before. On admission the tumour was irregular in outline, solid, and situated in the lower part of the abdomen, extending upwards as far as the umbilicus; it had a slight inclination to the left side, and was freely movable. On examination per vaginam a number of small hard tubercles could be felt through the posterior wall of the vagina; the os uteri was high up behind the pubes. On introducing the finger into the rectum it at once came into contact with a hard globular mass, resembling very much the fœtal head, there being also a well-marked suture. No material change took place in the patient's condition until May 16th, when morning sickness came on and lasted ten days. A diagnosis was a matter of considerable difficulty, as owing to the previous history of the case and condition of the parts pregnancy was very strongly suspected, but after some time had elapsed and none of the other signs of pregnancy made their appearance the case was considered to be one of ovarian growth, probably of a dermoid character. As the patient's health began to fail, it was deemed advisable to make an exploratory incision, and to be guided by circumstances.

On April 28th an incision two inches in length was made in the linea alba, and an ovarian tumour discovered. There were no adhesions, the pedicle was ligatured, and hæmorrhage, which gave some trouble, having been arrested, the wound was closed with carbolised silk sutures and then strapped with adhesive plaster. In the evening the temperature was 102·6°; pulse 140. The bowels acted. On the 30th she vomited. Temperature 98·6°; pulse 128. On May 2nd the pulse was very weak, 128; temperature 103°. Tongue dry and coated with a brown fur. Two grains of quinine were given every four hours and two teaspoonfuls of brandy every two hours. The wound was dressed. Next day when the wound was dressed the sutures were removed. The pulse was counted with difficulty, about 160 per minute. Patient had been sick twice. She gradually sank and died on June 4th. The post-mortem revealed diffuse peritonitis, the whole of the abdominal organs being matted together.

The growth was a characteristic dermoid cyst, consisting of bone, cartilage, &c. It sprang from the right ovary, was multiple, the smaller cysts containing a thick gelatinous fluid. The inner surface of the cyst was made very uneven by being scattered over with circumscribed elevations, and there were also several tufts of hair two or three inches in length, of a fair colour, contained in the cyst. The bones resembled those of the fœtal skull, being in some places nodular, others laminar, and presenting a well-marked suture. In places the cyst wall was composed of cartilage.

CASE 4. *Antiseptic ovariotomy; recovery.*—Eliza R——, a domestic servant, aged twenty-five, single, was admitted Aug. 26th, 1879. She had felt out of health all the summer, but was able to continue her work up to three weeks before, when she noticed a swelling at the lower part of her abdomen in the median line; this had rapidly enlarged, but was not painful. Sickness had occasionally occurred in an evening. She menstruated quite regularly up to two months before admission.

On Sept. 9th the tumour extended one inch above the umbilicus, and the circumference of the abdomen (opposite the umbilicus) was 32 in., but by Oct. 3rd this had increased to 33½ in.

On Oct. 17th ovariotomy was performed antiseptically. An incision four inches in length was made. The cyst was unilocular, and contained a large quantity of fluid of a purulent character. The pedicle was ligatured as in the previous cases. In the evening nausea and vomiting came on, and lasted until the following day; they were arrested on the administration of beef-tea enemata. The urine also became of a dark greenish colour, due to the absorption of carbolic acid from the dressings, and continued so for several days.

On the fifth day (Oct. 22od) the dressings were removed, and it was found that, with the exception of a quarter of an inch at the upper part of the incision, the wound was quite healed. The sutures were taken out, and from this time the patient made an excellent recovery. She attended service in the hospital chapel on Nov. 2nd, and was discharged well Dec. 2nd, 1879.

Remarks.—Owing to the tumour beginning in the median line, the lubricated state of the vagina, and the soft and patulous condition of the os, there was at first some difficulty in diagnosing this case from pregnancy. Before the operation adhesions were expected to be found. As the patient appeared to suffer several slight attacks of peritonitis fortunately these expectations were not realised. The highest temperature registered after the operation was 99·6°, and the pulse never exceeded 98.

CASE 5. *Antiseptic ovariotomy; recovery.*—Susan H——, a barmaid, single and aged nineteen, was admitted Dec. 9th, 1879. She had previously (in 1877) been in the hospital for an abdominal swelling, when fluctuation was detected over the whole of the abdomen. An ovarian tumour was diagnosed, and she was tapped; but, owing to her fainting, only fifteen ounces of fluid were drawn off. During the next few days she passed an unusually large quantity of urine, and in a week the abdomen had returned to its normal size, leaving only a slight thickening in the left iliac region. The fluid removed was quite clear, not coagulable by heat or nitric acid; sp. gr. 1003, with a slight deposit on standing of epithelial cells and crystals of phosphate of lime.

The enlargement having reappeared it was decided to operate, and on December 12th ovariotomy was performed antiseptically. Twenty-three pints and a half of serous fluid were drawn off; sp. gr. 1010, slightly alkaline, and containing a small quantity of albumen. The cyst was unilocular, and sprang from the broad ligament on the left side. The pedicle was secured with a triple ligature. On the following day the temperature rose to 100·4°, but afterwards never reached more than 99·6°. The patient recovered without a bad symptom, and was discharged Jan. 6th, 1880.

CASE 6. *Antiseptic ovariotomy; recovery.*—Lucy A——, aged twenty-seven, single, had suffered from abdominal pains for three years. Eighteen months before admission she noticed a tumour in the right pelvic region. It had grown rapidly and become more painful during the last few months. She was admitted on August 17th, 1880, and on the 28th ovariotomy was performed antiseptically. The cyst was unilocular, and the pedicle was ligatured as in the previous cases. There was a large number of adhesions; posteriorly several coils of intestine were firmly attached to the cyst, whilst inferiorly it was bound down to the fundus of the uterus by a band of fibrous tissue, an inch broad and half an inch in thickness. The patient progressed very favourably, though her recovery was somewhat delayed owing to cystitis being set up by passing the catheter. Both pulse and temperature kept rather high for three weeks, the former varying between 100 and 132, the latter between 99° and 101°, but on the evenings of the tenth and seventeenth days after the operation the temperature reached 102°, it then came down to 99°, when it remained stationary for a time, after which it became normal.

The patient was discharged cured Oct. 25th.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Observations on the Value of Stethometry in the Prognosis of Chest Disease.

THE ordinary meeting of this Society was held on the 25th inst., J. E. Erichsen, Esq., F.R.S., President, in the chair. There was but a scanty attendance. Only one paper was read, which was a further contribution to "stethometry," by Dr. Ransome, detailing with great care the result of numerous observations made by him on the movements of the chest in pulmonary disease.

The following is an abstract of the paper, entitled "Further Observations on the Value of Stethometry in the Prognosis of Chest Disease," by ARTHUR RANSOME, M.D. The bearing of stethometry upon the prognosis of chronic bronchitis, asthma, emphysema, and pleurisy having been pointed out, this paper then deals more closely with the records of chest measurements of 102 persons affected with various forms of phthisis. Fifty of these cases were either chronic, or persons in whom the disease had become quiescent (twenty-five males and twenty-five females). Forty of these were acute (twenty males and twenty females), and twelve of them were exceptional cases, in whom the chest measurements could not be relied upon from their youth, and who had succumbed from accidental causes, such as hæmorrhage, &c. The points selected for the application of the stethometer were the middle points of the clavicles and the anterior ends of the third ribs, the movements measured being chiefly those in the (horizontally) forward and the (vertically) upward directions. In all cases the measurements were obtained in an interval of comparative quiescence of the disease, and cases complicated with extensive pleuritic adhesions were excluded from the tables. From these records it appears that—1. The respiratory movements are much smaller in acute than in chronic cases. In six of the acute cases no movement was perceptible in one or another of the directions of motion at one of the points examined. No such immobility was found in any of the chronic cases. The average forward push of the clavicle in acute cases, on the worse side, was 0·15 in., in chronic cases 0·29 in. This movement over the third ribs was on the average 0·25 in. in acute cases, and 0·54 in. in chronic cases. A similar contrast was remarked in the extent of the *upward* movements. The average upward movements of the clavicles in the male acute cases was 0·25 in. on the worse, and 0·30 in. on the better side; in females 0·26 in. and 0·38 in. respectively. In the chronic male cases the corresponding diminutions were 0·50 in. on both sides; in females 0·56 in. on the worse and 0·66 in. on the better side. The third ribs move upwards in acute male cases 0·36 in. on the worse, and 0·45 in. on the better side. In females the numbers are 0·38 in. on the worse, and 0·51 in. on the better side. In chronic cases these dimensions are for males 0·72 in. and 0·74 in.; for females 0·78 in. and 0·85 in. 2. There are certain peculiarities of chest movement in chronic and acute cases, arising out of the power of independent rib movements. This is shown (*a*) in the extreme restriction of motion of parts placed over an advancing softening of the lung in its comparative freedom over a quiescent vomica. The third stage of phthisis had been reached in thirty-three cases—twenty-one of the acute, and twelve of the chronic series. The average forward push of the clavicle in the chronic cases was more than double that in the acute series, and in half the former group there was actually a larger extent of motion over the site of a vomica than on the less affected side of the chest. The circumstance was not observed in any of the acute series. The third ribs show nearly three times the amount of forward movement in chronic than in acute cases, and in the former group the motion of the bone over the excavated lung exceeds that of the opposite side. (*b*) Efforts at compensation are made, by both clavicles and third ribs, in either an upward or a forward movement. When these efforts take place in the upward direction they must be regarded either as an unfavourable sign, or else as only a measure of the muscular power that the patient can bring to bear on the obstruction to healthy breathing. There were sixteen such cases of exaggerated upward movements amongst the chronic series, and six in the acute series. In the forward direction the effort at compensation has a distinctly favourable significance—it occurs fifteen times amongst the chronic cases and only twice doubtfully amongst the acute group. Much assistance may also be derived from repeated measurements of the same case, and instances are given of the kind of information thus obtainable. From the data afforded in this paper it was concluded—1. That a small amount of movement of the chest, especially in the forward direction, is of evil augury; and that when, in adults under forty, the forward push of the third rib is less than 0·35 in., there is reason to foretell a rapid course of the disease. 2. That we may usually give a favourable prognosis when in an adult there exists an inactive vomica, with a considerable extent of movement in the ribs overlying it; and the sign is still more favourable when the forward motion of the bone is greater than that of the corresponding point on the opposite side. 3. That an excessive or compensatory effort at *upward* movement tells us little as to the gravity of the disease, but a free compensatory *forward* movement is a favourable sign. 4. That stethometry must be regarded as only one of the elements of prognosis.—The PRESIDENT, in according the usual vote of thanks, remarked that the paper was one which required careful perusal, and that the author had extended into the domain of prognosis the precision with which pulmonary affections were now diagnosed.—Dr. BROADBENT said the value of the stethometer was that it directed attention to given points in chest disease, which might otherwise be passed by as of little importance. It would be of value if it did nothing more than help to form a prognosis in the early stages of disease, for it pointed out more accurately than the eye or hand the limitation of movements of the chest in such conditions. One point came clearly out—viz., that the greater comparative extent of upward movement was often compensatory for defective forward movement. All must recognise the

scrupulous care with which Dr. Ransome had made his observations and laid the points of his paper before the Society, realising more fully than had been done before the aid obtainable by definite and precise measurement of thoracic movements.—Dr. DOUGLAS POWELL said that all must be grateful for any aid in the prognosis of consumption, the peculiarly intermittent character of which rendered prognosis so difficult. These observations, which required so much skill and patience, especially when the difficulty of obtaining trustworthy records of the movements of the chest is considered, would be of great value for reference and guides to others—like the researches of Dr. Hutchinson with the spirometer. Dr. Powell had found the most valuable indication of the respiratory power in phthisis to be the power of expiration rather than that of inspiration; noting, that is, the degree to which the patient can empty the chest of residual air. The author's observations were also of value in correcting previous notions—e.g., the localised diminution of movement was generally regarded as evidence of chronic disease, but Dr. Ransome had shown that the movement was more impaired in acute than in chronic phthisis—in other words, that fixity was a sign of activity of progress of the disease, mobility of chronicity. Of course, in the stage of consolidation the movement in an acute case is limited; but when softening takes place the movement is generally freer; whilst if the disease become arrested, the walls flatten and movement is diminished.

The Society then adjourned.

MEDICAL SOCIETY OF LONDON.

Treatment of Nævi and other diseases by Ethylate of Sodium.

AT the meeting of this Society on the 17th inst., F. J. Gant, Esq., President, in the chair—

Dr. JOHN BRUNTON exhibited a case of Nævus of the Scalp, successfully treated by sodium ethylate, and also showed a case in which some nævoid spots on the face had been similarly dealt with.—Mr. WORDSWORTH declared that in many cases nævi spontaneously degenerated and disappeared—even after temporary increase—rendering operative measures unnecessary. But where they occupied situations liable to produce deformity, and when they were very large, they should be destroyed. On the eyelids they should be dealt with early, to avoid visible scars and contraction; several punctures with the cautery needle into the nævus itself being sufficient.—Mr. SPENCER WATSON had used sodium ethylate, but was not satisfied with the result, except for superficial nævi.—Mr. EDMUND OWEN also said that he had given it an extensive trial, and found it answer well in small superficial cases, but it had failed for deeper growths, which he had finally to treat with Paquelin's thermo-cautery. For small nævi almost any method availed, even the friction of clothing sufficed for their obliteration. The case exhibited by Dr. Brunton had been one year under treatment, and had required twelve applications of the caustic. The thermo-cautery had the advantages of rapidity of action and certainty.—Mr. ROYES BELL had also failed to get good results from sodium ethylate in larger nævi. He agreed with Mr. Wordsworth as to the advantages of leaving many of these cases to spontaneous cure. The length of time occupied in the treatment by the ethylate was an objection to its use.

Dr. RICHARDSON then read a paper "On Ethylate of Sodium in the Treatment of Nævus and other forms of Disease," the text of which will be found at p. 168.

Dr. ROUTH thought that the injection of this agent would prove useful in uterine and other fibroids. He had seen, especially in mammary tumours, marked benefit from injection of iodine, but the procedure was always followed by severe inflammation. He asked if there was much inflammation in the case of goitre treated by Dr. Richardson.—Mr. OWEN would like to hear from Dr. Richardson the exact and probable effect which would follow upon the solution being injected into the interior of a good-sized vessel in the thyroid gland. Would it, like the ferric solution, cause coagulation? If so, he would regard its use subcutaneously with the gravest apprehension. Looking to the effect which the ethylate had upon solid tissues, he should infer that its effect on the blood would be considerable, and its injection might not improbably be followed by thrombosis or secondary hæmorrhage. — Dr. WOAKES thought the treatment promised to afford a new departure in the case of goitre, in which the methods ordinarily in vogue were more or less abortive. Apprehensions of danger from injecting fluids into solid organs were groundless. It was a daily practice at the Throat Hospital to inject goitrous tumours chiefly with tincture of iodine, and he was not aware of a single mishap accruing beyond an occasional superficial abscess caused by the escape of a portion of the fluid into the subcutaneous areolar tissue. Injection of hypertrophied lymphatic glands, with dilute acetic acid, was common, and the results most favourable. All the accidents seemed to have occurred with the injection of perchloride of iron; but this, diluted, was constantly used in the treatment of cystic goitre, the cyst being first emptied through a cannula, the injection taking place into the cyst cavity, which in a few hours became a suppurating surface. Probably tannin in solution would supersede the use of iron for this purpose, though, with the observance of proper precautions, the injection into such structures would prove to be a perfectly safe procedure; and on this ground it seemed probable that Dr. Richardson's suggestion would prove a valuable one.—Dr. CROCKER referred to a case of death from abscess due to injection of perchloride of iron into a thyroid tumour.—Mr. MCHARDY also alluded to a case of cystic goitre, in which death resulted from a like injection.—Dr. BRUNTON, in reply, said that he had applied the agent about twelve times in the case of the child. He used a glass-rod, applying the ethylate whenever the crust was removed easily. He considered the remedy to act in a threefold manner—as a caustic, an astringent, and as a coagulator.—Dr. RICHARDSON, in reply, said that he did not advise the hypodermic injection of ethylate of sodium, except in cases of extreme danger to life, and when other means had failed. It undoubtedly dissolved gland structures, and the addition of alcohol increased its coagulating effect. Nævi treated subcutaneously had not been so successful in result as when the agent was applied externally.

CAMBRIDGE MEDICAL SOCIETY.

Treatment of large Hydatid Cyst of Liver.

A MEETING of this Society was held on Friday, January 7th, Professor Paget, M.D., F.R.S., in the chair.

Dr. GROVE (St. Ives) gave an account of the Treatment by Aspiration and by Drainage of an unusually large Hydatid Cyst of the Liver. The patient was an unmarried woman, aged thirty-five, who had had symptoms for two years referable to the liver. When first seen on May 26th, 1880, the patient was suffering from acute pain in the right hypochondrium, where there was an increase in size. The pain and tenderness becoming more severe, she was seen by Dr. Latham in consultation. At this date (June 17th) the liver was found to extend as low as the crest of the ilium, it was hard and resistant, except just at the margin of the ribs, about two and a half inches from the median line, where there was a feeling of elasticity; on pressing at that point, and between the fourth and fifth intercostal spaces, there was a suspicion of fluctuation. Dulness on percussion from the lower margin of the third rib down to the level of the crest of the ilium, except over an area of about two inches in diameter (corresponding to the fourth, fifth, and sixth costal cartilages), which was distinctly tympanitic. The respiratory sounds were heard well only under the clavicle. Posteriorly a tympanitic note at lower angle of scapula and from that to the spine; normal resonance above that, and absolute dulness below. Over this posterior tympanitic area the respiratory sounds were feeble, and there was marked tremulous bronchophony. The patient, during the examination, felt much pain, especially at the tip of the right shoulder-blade, the whole right side being extremely sensitive. As she had occasionally profuse perspirations, this, with the other signs, made it not improbable that there was a suppurating hydatid cyst in the upper portion of the liver; but as the sense of fluctuation was very slight, it was considered advisable to wait a few days before proceeding to operative interference. To continue to take effervescing mixture and anodyne draughts. On June 21st the general condition was worse and the girth had increased four inches (to thirty-four inches). There was now an elastic distinctly

fluctuating tumour to be felt below the margin of the ribs. In consultation with Dr. Latham it was resolved to perform paracentesis. The puncture was made two inches to the right of the middle line and one inch below the costal cartilages; evacuation of nine pints and a half (imperial) of offensive semi-purulent fluid, containing numerous empty cysts. The operation was performed with the aspirator with a full-sized needle and occupied upwards of an hour. In the course of the following days there was some diarrhœa, the stools being of pale colour. On July 9th (evening) a rise of temperature was noted, with dry tongue and little appetite. The girth had again gone up to thirty-two inches, and was daily increasing; pain and oppressed breathing. On July 14th aspiration was again performed; seven pints and a half of bile-stained fluid were removed. Next day potassa fusa was applied somewhat to the right of the puncture to form an issue. The motions were devoid of bile. On the 18th the cyst was tapped through the eschar with trocar and cannula, the fluid removed being very biliary. Cavity washed out with chloride of zinc solution. An india-rubber drainage-tube nine inches long was introduced through the cannula, the latter was then withdrawn and the tube retained. The cyst was washed out twice daily with 2 per cent. of carbolic solution; the discharges were deeply stained with bile; entire absence of bile in the stools. For several days from July 21st the patient became weaker, emaciated, with sickness and diarrhœa. Bile began to reappear in the stools, and for two weeks from August 1st there was a great improvement, the chief trouble being constipation, which was relieved by enemata. On August 14th Dr. Grove was called up, and found the patient suffering severe pain in abdomen, with furred tongue and loss of appetite; large flow of bile from cyst. The cyst had contracted considerably, and on August 20th it contained only one syringeful. The stools became natural, and she continued to improve until, about the middle of September, the tube, which had been shortened from time to time to about three inches, was removed; granulations had all but closed the orifice, and the wound was allowed to heal.—Dr. LATHAM, who had seen the case in consultation, remarked on the rapidity with which the cyst had enlarged, both in the first instance and after the fluid had been once removed. There was tympanitic resonance over the fifth, sixth, and seventh costal cartilages, and, on auscultation, distinct tremulous bronchophony. There was a certain amount of air in the cyst; and, at the second puncturing, there was a great rush of air. He had once before observed tremulous bronchophony where the fluid was not in the pleural cavity. The largest-sized aspirating needle was used, but even that became immediately blocked by the cysts, and it had to be cleared many times in the course of the operation. The amount of fluid removed on the two occasions was 340 oz., an unusually large, if not unprecedented amount. The discharge by the drainage-tube was almost pure bile, and it was probable that the destructive changes in the cyst had opened a communication with one of the larger bile-ducts.

(To be concluded.)

YORKSHIRE ASSOCIATION OF MEDICAL OFFICERS OF HEALTH.

A MEETING of the members of this association was held at Wakefield on Wednesday, Jan. 19th. The members of the association assembled at the Town Hall, and then proceeded to visit the Infectious Diseases Hospital recently erected by the Corporation of Wakefield, near Park Hills, and the West Riding Pauper Lunatic Asylum, where they were courteously received by Dr. Major, the medical superintendent. In the afternoon, a general meeting of the members was held in one of the committee-rooms of the new Town Hall. The proceedings, which occupied two hours, were of an interesting character. Mr. S. W. North, of York, the medical officer of health for that city, and the president of the association, occupied the chair, and there were also present the following gentlemen:—Mr. R. Kemp (Horbury), F. H. Wood (Wakefield), Mr. Wade, Dr. Scott (Ilkley), Dr. Farquhar (Pudsey), Dr. Hime (Sheffield), Dr. Butterfield (Bradford), and one of the Commissioners appointed to inquire into "the woolsorters' disease," Mr. J. Mitchell Wilson (Doncaster), secretary to the association, and Ald. Sellars, and Councillors Flower, Tattersall, and Sherwood, of Wakefield.—The PRESIDENT, in opening the proceedings, alluded to the great interest which is being taken at the present moment in regard to the prevention of infectious diseases. Referring to infant mortality, the President said that a very large number of deaths had taken place from diarrhœa and other causes, and arrangements were being made for a conference of medical officers of health to be held at Leeds or York in April to discuss the matter. The President also remarked that Dr. Barry, the late secretary to the association, had been appointed medical officer for the island of Cyprus, and during the meeting was elected an honorary member of the association.—Dr. WADE, the medical officer of health for Wakefield, then read a paper on the Sanitary Condition of Wakefield during the last Ten Years, and it was followed by an interesting discussion, in which the President and Dr. Butterfield (Bradford), Dr. Farquhar (Pudsey), Dr. Hime (Sheffield), and Dr. Wilson (Doncaster), took part. The last-named gentleman, in referring to a suggestion that schools should be closed as one means of preventing the spread of infectious diseases, said that this was a question in which teachers were greatly interested, because, if children were not permitted to attend school regularly, teachers lost a portion of the Government grant. He therefore thought that the matter was one which ought to be laid clearly before the Education Department. — Mr. BUTTERFIELD mentioned that a serious outbreak of scarlet fever had been caused at Bradford by two children who had had a mild atttack of it going to school before they had thoroughly recovered, and by other children in the school amusing themselves by picking the skin off the fingers of the children who had been infected. Mr. Butterfield then read some lengthy notes on "Woolsorters' Disease;" but as he and his fellow commissioners have not yet completed their inquiry, the representatives of the press were requested not to give publicity to the contents of his paper at present. Mr. Butterfield having replied to a few questions by Dr. Hime of Sheffield, the last-named gentleman exhibited a cheap and simple apparatus for testing the quality of milk.—A vote of thanks was given to the Mayor and Corporation for the use of the Town Hall, and subsequently some of the members dined together at the Bull Hotel.

WEST KENT MEDICO-CHIRURGICAL SOCIETY.

AT the fourth meeting of this Society, held on the 7th inst. at the Royal Kent Dispensary, Greenwich, Dr. Purvis in the chair, the following resolution was proposed by Dr. Purvis, and seconded by Mr. W. Lockhart, F.R.C.S.E., and carried unanimously:—"That the members of the West Kent Medico-Chirurgical Society tender to Dr. Habershon and Mr. Cooper Forster their cordial sympathy in the circumstances that have led to their resignation of the offices at Guy's Hospital, which they have so long filled with distinction and usefulness."

Dr. Galabin, Assistant Obstetrical Physician to Guy's Hospital, then read a paper on "Some cases of Tumours of the Abdomen simulating Ovarian Tumours." Dr. Galabin gave the details of several such cases which had come under his notice, which showed how very difficult it is to distinguish between such tumours, as several cases which were considered by himself and others to be ovarian, proved to be otherwise when operated on.

Reviews and Notices of Books.

Peruvian Bark: a Popular Account of the Introduction of the Chinchona Cultivation into British India. By CLEMENTS R. MARKHAM, C.B., F.R.S. London: Murray. 1880.

To introduce into one country the cultivation of a plant which is a native of another might seem a problem of the simplest practical character; but how complex and difficult the task may be, what energy and perseverance are necessary to overcome its difficulties, is well known to the few who are familiar with the history of the introduction of the cinchona plant into India. To those who are not, we commend the story as told in this not too prolix volume of 500 pages, by Mr. Clements Markham, to whose labours the achievement is almost entirely due.

As the work is intended for popular perusal, Mr. Markham begins with a sketch of the history of the Peruvian bark. He describes what many of our readers already know, the origin of the name from the lady who, first of Europeans, owed to the bark her recovery from fever—a lady who had entertained our own Prince Charles and Duke of Buckingham, and the ruins of whose castle at Chinchon still stand at the village of the same name, not far from Madrid. The omission by Linnæus of the first *h* in her name, when he designated the plant after her, is regretted by Mr. Markham and by others, as obscuring its origin, but the Linnæan orthography is now stereotyped by almost universal custom, on which our own endeavour, for some years past, to influence by example, has had no effect. "Quina," it is hardly necessary to say, has nothing to do with the name of the plant, being only the Peruvian name for bark.

The story, from the first discovery of the value of the bark to its latest transplantation, is a long and interesting one, marked by incidents of social interest and personal adventure, by many an instance of self-sacrifice and heroism, and also by many an example of rapacity, injustice, and stupidity. Religion and science each had its share in assistance or obstruction; the use of the bark was condemned by Protestants because it was brought from Peru by Jesuits, and the discovery of the actual plant from which the bark came was an indirect result of an attempt to ascertain the shape of the earth.

Mr. Markham describes at length the natural history of the several species of cinchona, and the particulars of the discovery and geographical habitat of each of the five groups of valuable forms—Loxa, and its "crown" barks; the western slopes of Chimborazo, and their red barks; the Colombian region; Northern Peru, where the "grey bark" grows; Southern Peru and Bolivia, with their precious Calisaya bark. When the value of the bark became recognised, the supply was in time threatened with extinction. The cinchona-gatherers destroyed the trees in getting the bark; they simply stripped it from them, and the barkless trees quickly died, root and all. In some instances, relying on the abundance of the supply, after a tree was cut down they did not even take the trouble to remove the bark from the under-side of the trunk. Hence in time every cinchona plant was destroyed for ten or twelve days' journey from villages which were once surrounded by them.

The need for quinine in India, the remoteness of the South American source, and the similarity of the climate of many parts of India to that of the cinchona regions of South America, led to a suggestion for its introduction of being made as long ago as 1839 by an honoured member of our profession, Dr. Royle. Twenty years were to pass, however, before steps were taken to carry out the suggestion. The Dutch were before us in enterprise, for in 1853 they introduced the plant into Java. But the undertaking was ill-planned. The varieties chosen turned out to be of little value; and one, which, being the most hardy, was chiefly cultivated, was found to be of no value at all. Dr. Royle renewed his attempts to get the Government to take some steps with regard to India, but died in 1857, unsuccessful. His words, however, lived after him; and in 1859 Mr. Markham, who had travelled much, for geographical survey, in the cinchona forests of Peru, resolved, at the request of the India Office, to devote himself to the work. It could not have fallen into better hands. With his special qualifications for the difficult task, Mr. Markham evidently unites great personal energy and organising power. It was resolved to apply to the Government to carry out the work, but the help thus afforded was scarcely efficient. It was decided that five expeditions should be despatched, one to each of the regions in which the valuable bark grows, since it was doubtful which species would best bear cultivation in India with least loss of its valuable properties. The most difficult of these expeditions, that into the forests of Caravaya, in which the Calisaya bark grows, was undertaken by Mr. Markham himself. The narrative of his journey, given in detail, is full of vivid interest. The journey from the small coast town on the Pacific coast had to be performed on mules, along for the most part unfrequented paths. They started from Islay on March 6th, 1860, and it was not until May 1st that the mountain forests were reached. Many of the roads were at their best like "back-attic stairs after an earthquake," while swollen rivers added to the difficulties and even peril of the journey. When they reached the cinchona districts, 5000 feet above the level of the sea, they had to penetrate into dense tropical forests, where no European had ever been before, and search long before they found the plants. Having succeeded in securing the needed specimens and commenced their return journey they found that their perils were not yet over. The people of the district had been excited by rumours that the export of the plants would ruin their bark trade, and were resolved that not a single plant should be carried away. It was necessary to avoid all towns and villages and to shape a direct compass course across the Cordilleras. In their journeys they were only saved from starvation by an occasional meeting with a friendly Indian, but ultimately reached the coast in safety. The other expeditions were equally successful. One of the most important of these was the search for the red bark by Dr. Spruce, to whose scientific character, energy, and perseverance Mr. Markham pays a high tribute. By the efforts of Messrs. Ledger and Cross in the other expeditions all difficulties were overcome in the end. Plants and seeds of all the cinchona species known to commerce were brought to the coast, and the plants satisfactorily established in Wardian cases. In a sad chapter Mr. Markham tells a very dark story of the insufficient recompense to those who, at the risk of life, and, in several instances, at the loss of health, effected this work. The original agreements were for comparatively small remuneration, so that, if the attempts were unsuccessful, little money loss should be incurred by the Government, the generosity of which was trusted to, should success reward the attempts—a trust ill-placed in every instance.

The selection of the most appropriate sites in India for the cinchona cultivation required much care. They were chosen under Mr. Markham's own supervision, guided by his experience and observation in South America. The first and most important plantation was in the well-known Nilgiri Hills, the most delightful climate in the world, where "the warmth is not heat, and the coolness is not cold"; and the plantation was successfully carried out by Mr. McIvor, the Superintendent of the Government Gardens at Utakamund. The experiments and results here and elsewhere are graphically narrated by Mr. Markham. By 1866 there were 244,871 trees permanently planted out. "The old jungle had disappeared, and in its place were the rows of Peruvian bark trees with their graceful and beautiful foliage." Numerous private plantations have since sprung up; no less than 290,000 cinchona plants and 503 ounces of seed having been given to the public up to 1875. A very important and promising discovery was made in 1873—that of a spontaneous hybrid, which contained three times as much alkaloid as the ordinary species.

The other cinchona plantations of India are next described, especially in British Sikkim and Ceylon. The climate of the latter is well adapted for the purpose, and the extent of cultivation and amount of labour promised a fair trial. So rapidly has the cultivation spread that in 1877 there were no less than 5578 acres under cultivation, and the number of trees now planted out is about seven millions. The entire cultivation in Ceylon is now carried out by private companies

and private proprietors; Government having, so far, only given its attention to the propagation, nursing, and classification of the plants.

The introduction of the cinchona plantation into India has been a financial success. The amount of quinine needed in India is very large, the yearly demand being about 10,000 lb., and the cost nearly £40,000. The total cost of the introduction and growth of the cinchona in India up to 1876 was £129,628, and by 1880 the whole capital amount had been paid off, and the plantations had begun to yield a clear annual profit. But this is not all. One of the objects urged from the first by Mr. Markham, and which has been partly attained, was the preparation of a cheap febrifuge for the use of the poor, and it has led to the manufacture of a similar febrifuge in Europe, and thus promises to be of immense benefit to the civilised world.

The East India barks have even entered the London market, and the position they take there is a very high one. In 1878-9 the Government bark sales showed a profit of £35,293. In 1879-80 the total yield of Peruvian bark from India and Ceylon was 1,172,000 lb., and it is now second in point of quantity only to Colombia, which exports six millions. But as regards quality the East Indian supply stands first; and some specimens have attained a higher price than has ever been reached by South American specimens. It is very depressing to learn that, in spite of this success, and promise of still greater success, the Government plantations have been neglected, and future prospects have been jeopardised, to secure large present results. This is the case chiefly in the Nilgiri plantations since the death of Mr. McIvor. In Sikkim more enlightened views have prevailed, and the true object of the cinchona plantation is understood and appreciated. It is probable that, under due management and fiscal regulation, the enterprise may in time come to be of vast financial importance to the Indian Empire. A writer in the *Pall Mall Gazette* of Sept. 18th, 1880, points out that it is probable that China will hereafter be among the largest and most constant customers for cheap febrifuge alkaloids from British India. Opium is now employed as the medicine which is cheapest and most readily obtained. If cinchona alkaloids should come into competition with opium, and obtain the preference by their lower price, their immense superiority would produce a revolution in the Chinese consumption of the two drugs. By this process a solution would be found for the dangers and uncertainties of the large opium revenue of India, and for the perplexing moral questions connected with it.

Hernia, Strangulated and Reducible. With Cure by Subcutaneous Injections, together with suggested and improved Methods for Kelotomy. Also, an Appendix giving a short Account of various new Surgical Instruments. By JOS. H. WARREN, M.D. Boston. London: Sampson Low and Co. 1880.

ALTHOUGH, in accordance with the title of the work, it embraces a good deal more, it is only the description of Dr. Warren's operation for the radical cure of reducible hernia that will prove of interest to most English surgeons. It will be remembered by some that many years ago an American surgeon, Dr. Heaton, visited London, and, under the patronage of Sir W. Fergusson and others, demonstrated an operation for the cure of hernia by means of a subcutaneous injection of a decoction of oak bark upon and around the hernial rings. Dr. Warren has devoted much attention to this subject, and professes to have improved, if not perfected, the original operation of Heaton. With a special syringe armed with a flat blunt oval needle spirally twisted he injects a few drops of a mixture of decoction of oak bark, ether, alcohol, and morphia along the hernial canal, and especially around the "rings." By this he excites an exudation of plastic lymph, which closes the rings and canal, and prevents the redescent of the hernia. There are of course many details of the operation and after-treatment that our space forbids us to notice fully here, which have in view the protection of the peritoneum and neighbouring vessels, and the complete organisation of the lymph before any strain is put upon it. Considerable success is claimed for this method by Dr. Warren, who says that he has cured as many as from 80 to 85 per cent. of cases operated upon; but unfortunately we have no statistics at all given us, and the statement is confessedly a merely approximative one. Dr. Warren visited this country last autumn, and operated on some cases of Mr. Bryant's at Guy's Hospital, and it would be interesting to know from an independent source what success he then achieved, and also whether Mr. Bryant has himself practised this method subsequently, and if so with what results. The benefit conferred upon mankind by anyone who would introduce a simple and effectual cure for hernia would be almost incalculable, and all will receive with cordiality any honest attempt to attain such an end. The author's spiral-ended or vermicular instruments were exhibited at Cambridge in August last, and have been noticed in our columns.

THE CHLOROTIC MURMUR.

To the Editor of THE LANCET.

SIR,—I note that in your last issue Dr. Byrom Bramwell somewhat unwarrantably couples Naunyn's name with mine in a statement he makes as to the chlorotic murmur, in which he quite mistakes my views.

To Naunyn belongs the great merit of first showing that a murmur often found in mitral stenosis in the neighbourhood of the pulmonary artery is not arterial, but auricular, in character. I am not aware that Naunyn has written anything at all about the chlorotic murmur. To myself alone belongs the merit or demerit of connecting together the observations of Beau, &c., as to the dilatation of the heart in chlorosis, with Naunyn's observation as to the dependence of a basic systolic murmur having a certain well-defined position of maximum intensity upon mitral regurgitation. I have endeavoured to show that the chlorotic murmur has this position of maximum intensity, and that the assumption that it depends upon curable mitral regurgitation is the only one which is consistent with the mode in which this murmur progresses from area to area, or which can explain and make intelligible the various views which have been held as to its origin. I have nowhere denied that the chlorotic murmur is ever arterial; I have only endeavoured to prove that in its earliest phase it is strictly cardiac in character, and that the arterial murmur in chlorosis is a late development, largely due, as Beau has pointed out, to the large blood wave sent on by the dilated and somewhat hypertrophied left ventricle. As my second edition is not yet ready, and the first is out of print, I may for the present refer Dr. Bramwell to a paper on "The Position and Mechanism of the Hæmic Murmur," published at page 383 of THE LANCET in September, 1877, where my views will be found fully detailed.

I only notice this misstatement in self-defence, but I had better guard myself against being supposed to homologate all the other doctrines propounded by Dr. Bramwell in the same paper, some of which I regard as inconsistent with fact, and others with physiology and with the physics of the circulation; in this respect I may specially refer to the theory that the aortic valves close first in the case of a reduplicated second accompanying mitral stenosis.

I am, Sir, yours sincerely,

Edinburgh, Jan. 20th, 1881. GEORGE W. BALFOUR.

PRESENTATION.—On Saturday, the 22nd inst., Dr. C. Swaby-Smith of Seaforth, near Liverpool, was presented with an appropriate address accompanied with a purse of money by the Committee of Management of the Seaforth National Schools, in recognition of his services as Honorary Secretary during the past seven years.

THE LANCET.

LONDON: SATURDAY, JANUARY 29, 1881.

OUR readers will remember that a question, describable as one of etiquette, and arising out of the case of REGINA *v.* INGLE, tried at the Central Criminal Court August 5th, 1880, was referred to the President and Censors of the Royal College of Physicians. The facts may be recalled in a few sentences. LOUISA MORGAN, a married woman, aged twenty-six, was admitted at Guy's Hospital, under the care of Dr. PAVY, on June 9th, with maladies which, either at that time or afterwards, were recognised as "old and quiescent phthisis, suppurating cyst in broad ligaments, acute inflammatory mass (tubercular) in cortex of brain." The case ended by the death of the patient on July 21st. On July 6th LOUISA MORGAN was found to have become suddenly worse, and it appeared that on the previous day she had, without the instructions of the physician, received "a very prolonged bath," with "almost cold water, remained in it for a considerable time," and seemed "to have suffered from a severe mental shock." Just at that time Guy's Hospital was in the height of its troubles under a "new system of nursing" which the medical staff did not approve, and Dr. PAVY believing that the death of his patient was accelerated by the use of the bath and the manner in which it was administered, an inquest was held, and the Nurse INGLE committed for manslaughter. The case was detailed, and its principal bearings discussed in these columns, on August 14th, 1880. The main features will be, therefore, as fresh as need be in the recollection of all who care to follow the issue. Sir WILLIAM GULL, a consulting physician of Guy's Hospital, not having seen the patient during her life or her body after death, and therefore basing his judgment of the case on the evidence given by Dr. PAVY at the inquest, together with certain clinical notes and records of the post-mortem examination, arrived at the conclusion that the death was due to disease existing prior to the bath, and that, in point of fact, the nurse was unduly pressed. Acting on this view of the case, he appeared in Court and gave evidence which tended to show that the pathological condition of the deceased had not been fully recognised, and that the death might be fairly referred to natural causes.

Setting aside, for the moment, the terms and manner of this evidence, the question arose whether it was in accord with professional etiquette for a physician not concerned in the case, but connected with the hospital, to appear in opposition to a colleague, and publicly impugn the accuracy of his diagnosis without having himself seen the patient or even examined her body. It was obvious, and is admitted on all hands, that the presumption set up and maintained by Sir WILLIAM GULL on behalf of the nurse rested on an assumption of error in the view taken of the disease by Dr. PAVY. If the physician in attendance was right, the death had been accelerated by the bath. If the physician *not* in attendance was right, the death occurred from the natural development of the disease. Both opinions could not be right; and inasmuch as one was formed at the bedside and in the post-mortem room, while the other rested on second-hand evidence, it became a question of etiquette referable to the College of Physicians whether the proceedings taken and the evidence given by Sir WILLIAM GULL were strictly professional. The President and Censors of the College have replied as follows:—

"The President and Censors of the Royal College of Physicians, having carefully considered Dr. Pavy's complaint, and Sir William Gull's reply to that complaint, do not deem the character of the evidence which a Fellow or Member of the College has given on oath in a Court of Justice a proper subject to investigate when the Court has expressed itself satisfied in regard of the truthfulness and sincerity of the witness. They consider Sir William Gull, holding the opinions he expressed on oath, justified in going into Court. They are further of opinion that Dr. Pavy's diagnosis and treatment of the woman afford no grounds for any remarks calculated to disparage his well-deserved reputation as an eminent and skilful physician."

Could anything be more grotesque? After carefully considering the statements of Dr. PAVY in appeal, and Sir WILLIAM GULL in rejoinder, the President and Censors "do not deem the character of the evidence which a Fellow or Member of the College has given on oath in a Court of Justice a proper subject to investigate when the Court has expressed itself satisfied in regard of the truthfulness and sincerity of the witness." If this is the principle on which the College acts, why did not the Board at the outset decline to consider the case? Or was it only after making an attempt to get to the bottom of the question they discovered that it was one into which they had no business to pry? Then, again, what in the name of common sense does the College mean by a court of justice expressing itself as satisfied of the truthfulness and sincerity of a witness? It must be perfectly well known to every member of the Board that it is not the practice of courts so to express themselves. Witnesses do not commonly make their exit with certificates of truthfulness and sincerity. There was no question as to the "truthfulness and sincerity" of the evidence given by Sir WILLIAM GULL and Dr. PAVY. It would be an insult to these gentlemen to suppose they needed the expressed satisfaction of any court to accredit their testimony. Yet this is the ground on which the President and Censors declined to investigate the character of the evidence given! Having thus delivered itself, the same authority proceeds to declare that "Sir WILLIAM GULL, holding the opinions he expressed on oath, was justified in going into court," but is "further of opinion that Dr. PAVY'S diagnosis and treatment of the woman afford no grounds for any remarks calculated to disparage his well-deserved reputation as an eminent and skilful physician." Why the sole aim and purpose of Sir WILLIAM GULL'S evidence—the only effect it could have in the case—was to show that Dr. PAVY'S diagnosis had been defective! A decision which decides nothing, which rests on contradictory propositions, and stultifies itself will not satisfy the profession, and we should be astonished to hear that it gave the least comfort to either of the gentlemen interested in the appeal. The President and Censors of the Royal College of Physicians have again signally proved the incompetency of that august body to act as a tribunal of etiquette. Whatever else it may be fit for, it cannot rule the practice of the profession or lay down

principles of conduct by which the amenities of professional life can be governed, so that right may be done to all men, and a good understanding may prevail. The final appeal now lies to the profession, and we will not shrink from an expression of the opinion which, as we] believe, the profession has formed.

Sir WILLIAM GULL, beyond question, acted with perfect sincerity and the nigh motive of sympathy with an accused person whom he believed to be unduly pressed. He conceived, on reading the reports of the case, that the death might have been due to the disease and not to the bath, and so feeling, he came forward, or consented to be called, in defence. In thus acting, we have no doubt, he intended to serve the cause of justice and scientific truth, but we are not the less on that account of opinion that Sir WILLIAM GULL was wrong. It ought to have been evident to him that, as consulting physician of the hospital, it was a duty he owed his colleagues to confer with them before acting. It cannot be forgotten that he knew nothing of the case except by report, or obviously imperfect and insufficient documentary evidence. It is at all times a grave step to impugn the accuracy of a diagnosis after the death of the patient, and we can scarcely conceive of circumstances under which a practitioner would be justified in so doing without something much more trustworthy, as the material of a retrospective judgment, than any evidence or testimony Sir WILLIAM GULL had before him. We are bound to say that the clinical report, which we publish in another column, does not appear to us to convey any definite information in the case. We think it was a mistake to produce such a report in Court. There is, or ought to be, a full and clear record of every case treated in a public hospital, on which reliance can be placed. If such reports do not exist at Guy's Hospital, it is impossible to think that hospital has progressed with the times. Such records were duly and diligently made by the resident officers of hospitals thirty years ago. Why are they not made now? Have modern improvements in clinical method rendered close and accurate observation unnecessary? We do not see that Sir WILLIAM GULL—once in the witness-box and committed to the error of appearing in reference to a case of which he had no personal knowledge—can be blamed for commenting on the clinical notes and reports before the Court, seeing that they had been legally put in evidence. We think he would have done wisely to decline giving any opinion on grounds so meagre, but the documents in question were legally part of the case for the prosecution. Dr. PAVY'S position in the matter is, of course, unaffected by what has transpired. No member of the profession—including Sir WILLIAM GULL himself—ever entertained a thought disparaging to that distinguished physician.

The *contretemps* has been one of a most regrettable character, and the sooner it is forgotten the better. Meanwhile, we must say that the course taken by Dr. PAVY in declining to give a certificate of the cause of death, and thus necessitating an inquest, was inevitable, and in the interests of simple justice and common humanity. With the legal issue of the case neither the physician nor the profession have any concern. It would not be tolerated that a nurse should administer a bath without the instructions of the medical officer in charge of the case. As death followed in a manner which was thought to connect the bath with the fatal issue, it was a plain duty to refer the facts to judicial inquiry. The only subjects of professional regret are those to which we have adverted—namely, that Sir WILLIAM GULL should have deemed it a matter of personal duty, and consistent with his position as a consultee and holding official relations with the acting staff of Guy's Hospital, to interpose, or, interposing, to base any critical and retrospective opinion of the case on such slender and manifestly untrustworthy reports as were at his disposal; and that the physicians of Guy's Hospital do not cause to be kept and preserved clinical records of every case treated in the wards of that institution, made by skilled and responsible qualified observers, analogous to the qualified and salaried house-physicians and house-surgeons of times past, and of a nature to be produced in evidence on any emergency, without question as to their value, or the possibility of their being either repudiated or impugned. Surely this should form part of the duty of a hospital staff. It cannot be that only private records are required? There ought clearly to be a hospital clinical register duly kept and officially preserved. The profession may now hope that we have heard the last of a case which it has been most painful to investigate, and from the consideration of which we retire with a sense of relief. It is a story that points its own moral; enforcing the need of *esprit de corps*, and teaching a lesson of fraternity which the profession should be careful to learn and refuse to allow its members to ignore.

SINCE the use of the Hampstead Hospital of the Metropolitan Asylums Board for the reception of cases of small-pox in 1871-72, the common belief of the population resident in the near vicinity of the hospital that the contagion of the small-pox patients accumulated there was diffused from the hospital buildings to susceptible people inhabiting adjacent houses has become firmer and firmer. Each successive use of the hospital for small-pox has appeared to them to lend support to this belief, and later events in connexion with the small-pox hospitals of the Asylums Board at Homerton, Stockwell, and Fulham have been held to add further confirmation to it. But although ten years have passed since the rumour of this belief first reached the public generally, and within that period has grown upon the public so as to form now a formidable impediment to the provision of proper hospital room for the accommodation of small-pox patients, not only in the metropolis, but also in the provinces, no sufficient investigation has been made by those whose duty we hold it was to make such investigation into the circumstances under which the rumour first arose, and into the degree of truth or error underlying it, and the belief which has now so generally grown out of it. There were two points to be considered—first, the strictly medical point of the conditions under which, and extent to which, the contagion of small-pox admitted of being diffused through the atmosphere; and subordinate to this the indirect means in which the contagion might be apt to be disseminated in the carrying of small-pox patients to a hospital, and their dismissal thence when convalescent. Next, and depending upon the answers to be given to the first question, there was that of the public policy involved in

the accumulation of large numbers of small-pox patients in the near vicinity of inhabited houses.

With regard to the first question, at the time of the establishment of the Asylums Board Small-pox Hospitals all trustworthy medical evidence pointed to the conclusion that fear of diffusion of small-pox contagion through the atmosphere from a ward occupied by small-pox patients need not be entertained, and that the indirect means of dissemination of the contagion by patients conveyed to and dismissed from a small-pox hospital might be readily controlled. And these general conclusions were apparently fully confirmed by the results of the inquiry made by THE LANCET Sanitary Commission when the rumour of extension of small-pox from the Hampstead Hospital to neighbouring houses became alarming. The Commission was unable to ascertain any reasonable ground for the belief that contagion had been diffused from the wards through the atmosphere; and such evidence of extension as was discovered pointed to indirect but well-known ways in which small-pox is disseminated, and it was found difficult in all cases to say whether the extension came from patients in hospital or from patients among the general population outside the hospital, who had contracted the disease elsewhere in the metropolis. One thing, however, was made evident, that full light upon the subject could only be obtained by inquiry in detail into individual cases of asserted contraction of the disease from the hospital, and this alone could be done by the Central Government itself undertaking the inquiry.

And here we come to the initial misfortune of the whole of this troubled question. The Metropolitan Asylums Board at the time of the institution of the metropolitan small-pox hospitals was purely a Poor-law authority, and, acting strictly within its legal functions, it ignored almost wholly the general public health phase of these hospitals. In their establishment for Poor-law purposes, the principles as to infectious disease hospitals involved in the Sanitary Act, 1866, were overlooked, and in the whole of the discussions which took place upon these hospitals the department of the Government then concerned with the public health administration of the kingdom—namely, the Privy Council—was, we believe, never consulted! But, more astonishing still, when the Poor-law Commissioners and their functions were merged in the Local Government Board, which had entrusted to it both the Poor-law and Public Health administration of the kingdom, still the public health aspect of these hospitals was ignored, and, as a consequence, their usefulness is now gravely impeded, and, we learn on good authority, the erection of infectious disease hospitals throughout the kingdom brought practically to a standstill. In another column our readers will be glad to see that the Local Government Board appears at last to be recovering from the judicial blindness which in this respect has fallen upon them. It is known that Dr. THORNE THORNE has been for some time engaged in an inquiry on, and the results obtained from, the erection of infectious disease hospitals in various parts of the kingdom. It now appears that he is devoting his attention, among other things, particularly to the question of extension of disease from them. In continuation of that inquiry he has now been directed, in conjunction with Mr. W. H. POWER, to inquire into the reported extension of the contagion of small-pox from the Metropolitan Asylums Board's small-pox hospital at Fulham. As a first step in this important inquiry, Dr. THORNE THORNE has issued a circular to the medical practitioners residing within a mile of the Fulham Hospital asking for information as to *all* cases of small-pox falling under their observation during the next three months, and for their assistance in tracing these cases to their source. Here, then, we have an inquiry begun in the metropolis of a sort which can alone help to a full knowledge of the influence of the metropolitan small-pox hospitals in respect to the dissemination of contagion in their neighbourhoods. Having regard to the importance of the professional and public questions at issue, we sincerely trust that Dr. THORNE THORNE and Mr. W. H. POWER will receive from the medical profession in Fulham and the vicinity of the hospital the most cordial assistance.

THE answer of Mr. MUNDELLA to MR. ERRINGTON on the subject of Medical Legislation, which will be found in our Parliamentary notes of last week, seems to us as satisfactory as it could be in the most exceptional circumstances of the Legislature. Mr. MUNDELLA sees no probability of a Medical Bill being discussed and receiving proper attention this session, and therefore the Government did not intend to introduce a Bill; "but they thought it probable that some advantage would result from the continuation of the inquiry" by the Select Committee. The Vice-President said the matter was under consideration, and he promised to confer with Mr. ERRINGTON about it. To our thinking the evidence obtained already by the Select Committee of the last Parliament contains ground enough for a Bill amending the constitution and powers of the Council, and the constitution of the Licensing Boards of the kingdom. Without the Government accepting the responsibility of formulating a Bill, it may yet see its way to support a measure which is announced as being framed by a conference representing pretty fully the profession itself, and introduced by Mr. HARDCASTLE and others. This Bill will, it is stated, be very shortly before us and the public. If a satisfactory measure, it should be pressed on the attention of the House of Commons, and either adopted absolutely, or, if a Committee is to be appointed, it should be referred to the Committee with the other Bills which have been more or less considered. We consider the case ripe for legislation. If ever a public body has proved itself costly and incapable, it is the Medical Council, which is, unfortunately, the official source of all information to Government. The competing and complicated Examining Boards, with their half diplomas, are a scandal of fifty years' standing; and the imperfection of the means of distinguishing qualified from unqualified practitioners, with the consequent prevalence of fraud and imposture, are notorious public evils. So far we think the case for Reform "ripe and over-ripe." Still, we accept Mr. MUNDELLA'S language in perfect good faith. If he thinks that further opportunity should be given for developing the case for or against legislation, and that there is no probability of the Government accepting and helping forward a good Bill even prepared to their hand, then we shall acquiesce in the further inquiry, feeling

that it can only go to confirm the case for legislation. Before finally deciding, after consultation with Mr. ERRINGTON, Mr. MUNDELLA should certainly consider the Bill introduced by Mr. HARDCASTLE, purporting, as it does, to represent all classes and interests of the profession.

WE lately described the interesting experiments of Dr. BROWN-SÉQUARD on the effect of the application of chloroform to the skin on the functions of the central nervous system. It has been objected that the effects might possibly be due to the inhalation of some of the chloroform vapour. He has therefore repeated his experiments, and with the precaution of making the animal breathe air from another floor of the laboratory than that in which the experiments were made, its head being placed within a tube. The results obtained were the same as those already described, the only difference being that the period of excitement which usually precedes that of complete resolution, was a little longer than in the experiments already published. During this period, which is frequent, although not constant, the respiratory and cardiac movements are more rapid and more energetic. The animal cries and is disturbed—it appears hyperæsthetic, and its rectal temperature is raised a fifth or a quarter of a degree Centigrade.

Dr. BROWN-SÉQUARD, in a fresh series of experiments, has ascertained that the influence of chloroform on the mucous membranes is, as a rule, much more rapid and energetic than when applied to the skin. In these observations also the animals (dogs, cats, rabbits, and guinea-pigs) were made to breathe, by means of a tube fixed in the trachea, air coming from a distant part of the laboratory. Inhibition of the heart and respiration was invariably produced in a very brief, though variable time. Moreover, the loss of sensibility, of reflex action, and general resolution, with arrest of the exchange between the tissues and the blood, were frequently observed almost immediately after the application of the chloroform to the mucous membranes of the nose and larynx, or when it was poured into the mouth of a guinea-pig or rabbit. But, strange to say, the application of chloroform to the posterior part of the mucous membrane of the mouth of the dog, or to the surface of the pharynx, always produced the opposite effect to the inhibition observed in the other animals. Respiration is greatly augmented, one dog, for instance, breathing 160 times a minute. Thus the effect in the same animal is altogether different when the chloroform is applied to the laryngeal mucous membrane, than when it is applied to the adjacent mucous membrane in the pharynx and mouth.

The influence of chloroform poured into one nostril upon the diaphragm and phrenic nerves is exactly the same as that produced when it is applied to the side of the thorax or to the shoulder. There is a loss of the equilibrium between the action of the two halves of the diaphragmatic apparatus; the phrenic nerve and the half of the diaphragm on the side corresponding to the nostril irritated become more energetic both in the degree and in the duration of their action, after the thorax has been opened, while those on the other side present the opposite condition.

Chloral hydrate, even in the most concentrated solution, when applied to the skin, does not usually produce any of the anæsthetic or other effects which follow its injection into a vein or beneath the skin. This is, however, not true when a large area of the skin is irritated by anhydrous chloral. The effects of this are perfectly analogous to those of the application of chloroform. The only differences are that the chloral acts more slowly, but causes death more readily; that it causes pulmonary, renal, and intestinal hæmorrhages more frequently than chloroform, and that it produces abundant secretions from various abdominal glands, and so causes diarrhœa, an effect which is never produced by chloroform. Chloral seems to cause glycosuria, which chloroform never does, and is apparently absorbed by the vessels of the skin to a much greater extent than chloroform. Inhalations of anhydrous chloral or its application to the skin, do not produce anæsthesia except at the moment of death. In the guinea-pig especially, which is rendered anæsthetic so readily by the inhalation of a very small quantity of the vapour of chloroform, the inhalation of chloral has very little anæsthetic effect.

WE observe, with regret, that before the promised Warrant regulating the conditions of service in the Medical Department of the Navy has been promulgated, the usual advertisement has been issued by the Admiralty of an examination of candidates for commissions, to be held on Feb. 14th and following days. We cannot but think that in adopting this course they have committed a serious mistake. It is true that an intimation is given that "new regulations giving naval medical officers generally the same relative pay, position, &c., with reference to Army medical officers, as formerly existed, will shortly be published." But this is surely much too vague a statement of benefits to be conferred to satisfy any of the class of young medical men who would be likely to prove desirable candidates, and it refers only to the relative position with regard to the Army medical officers. Nothing is said of any intended change in the regulations regarding compulsory half-pay, nor of the privilege of choice of cabins according to rank being assured to them, nor of the abolition of the obnoxious rule requiring five years' service in the rank of Deputy before being eligible for promotion to that of Inspector-General. We are unwilling to suppose that there is any reason for withholding the Warrant till after the examinations are over, but we cannot understand the delay. The failure to obtain candidates has been too long manifest. The Committee appointed to inquire into the causes of this has long since made its report. There has been abundance of time to consider this report and to decide upon the necessary measures, and the wording of the advertisement itself seems to imply that these have already been settled. Why, then, have they not been published? We are most reluctant to say anything that would even seem to be injurious to the public service; but a sense of duty to the profession, and an earnest desire to promote the best interests alike of the Department and of the Navy generally, compel us to advise any medical men who may be desirous of entering the Service to withhold their applications till the new Warrant makes its appearance. We can conceive few things more injurious than that men should engage to enter a Service on unknown conditions and vague promises, or more likely to create a discontented and inefficient Department should these prove to be less satisfactory than was expected. Up

to the time of our going to press the Warrant is not, at least, in the hands of the profession. We would urge in the strongest manner upon the Admiralty the expediency of bringing out the Warrant at once if they desire to have a fair supply of well-qualified candidates. The delay which has taken place has already diminished the chance of an adequate number being obtained on this occasion; but, unless prompt measures are adopted, there is every probability of the intended examination proving as complete a failure as those of the last two years.

Annotations.

"Ne quid nimis."

FROST AND MORTALITY.

THE fatal effect of severe winter weather, called seasonable, upon the public health is once more exemplified in the Registrar-General's weekly return. During the six weeks of mild winter weather ending 8th inst. the weekly number of deaths in the twenty large English towns dealt with in that return averaged 2971, whereas in the two following weeks they rose to 3444 and 4199. This represents an excess of mortality in the two weeks equal to 1701 deaths in the twenty towns. It has often been shown in the reports of the Registrar-General that the effect of intense cold is fully as great upon the mortality of rural as upon that of urban populations. We may therefore assume that the effect of the severe frost which set in on the 12th inst. on the registered mortality of England and Wales up to Saturday, 22nd inst., was to add to the register the record of not less than 5749 deaths of persons who would have survived if the mild weather had continued. This simply represents the number of those killed outright by the first week of the frost, and affords but a slight indication of what the losses to the population would have been from a continuation of the intense cold. The above figures take no account of the wounded in the first week's conflict with the weather, who will the more readily succumb if the conflict be prolonged. It will be many weeks before it will be possible to sum up the total losses due to this arctic weather. It must not be supposed that the losses fall chiefly upon the weakly, the elderly, and infirm, as these figures show that the largest proportional losses were among male adults aged from thirty to fifty, upon those whose occupations entail upon them most risk of exposure.

PASSIVE CONGESTION OF THE SPLEEN.

AT the suggestion of Virchow, the histological changes in the spleen which result from passive congestion have been studied very carefully by Dr. R. Nikolaides. In the indurated organ, the naked eye can detect a thick white layer around the vessels, which renders the tint of the section a paler red than might be expected. Under the microscope the walls of the bloodvessels, and especially those of the arteries, are seen to be enormously thickened by an increase of the adventitia and the adjacent zone of tissue, which passes gradually into the neighbouring reticulum of the splenic pulp. The trabeculæ are thickened, and the contiguous cells of the pulp undergo atrophy, just as do the outer cells of the acini of the liver in cirrhosis. These changes are more or less marked in all congested spleens, and confer upon the organ its increased density. Their degree appears to depend upon the slowness with which the mechanical congestion is developed. Besides these changes, alterations occur also in the intima of the vessels. They are most marked in the arteries, and are only found in the veins in very chronic cases. In the veins the change consists in merely fatty degeneration; but the inner coat of the arteries presents an overgrowth of all the connective tissue layers—a true endarteritis, similar to that which Virchow has described in the veins of some other organs, as the lungs and liver, in passive congestion. It is difficult to say whether the muscular coat of the vessels is thickened or not; but Nikolaides believes that there is a considerable increase in the circular muscular fibres. Not only is this conclusion suggested by histological examination, but it is remarked that the mechanical congestion of the spleen never entails the degree of hyperæmia met with in other organs, as the liver and the kidney, in spite of the fact that the circulatory arrangement of the spleen is highly favourable to the occurrence of such hyperæmia. This fact is regarded as supporting the view that in congestion the muscular walls of the arteries contract, overgrow, and lessen the hyperæmia. The evidence on this point seems scarcely conclusive. Some share in this effect might be ascribed to an overaction of the muscular fibres proper to the splenic pulp, since it is difficult to understand, without such overaction, how the blood could be lessened in an organ, like the spleen, destitute of capillaries, by contraction of the arteries, if there exists an obstruction to the exit of blood. The splenic follicles, Nikolaides believes to take no part in the overgrowth of tissue which results from passive congestion.

SANITARY PROGRESS IN ARCHITECTURE.

A REFERENCE to the last number of our excellent contemporary the *Builder* affords conclusive evidence that the members of the architectural profession are gradually becoming fully alive to the necessity of attending to the sanitary arrangements of our public and private buildings. We find, in the first place, an extensive report of a debate at the Royal Institute of British Architects on the relations of sanitary science to civil architecture. The debate was *à propos* of a very able paper read by Mr. E. C. Robins, F.S.A., the Architect to the City Guilds, on November 29th, 1880; and as one evening was insufficient for so extensive a subject the discussion was resumed on the 17th inst., when, after a very interesting debate, it was found necessary to again adjourn it till the 14th of February next. We feel no little sympathy with those gentlemen who regard architecture mainly as a fine art (and who are furnishing us with edifices calculated to please the eye to a maximum extent), yet find that the requirements of civilisation and modern city life necessitate their directing attention to matters which are the very reverse of æsthetic. When we think of a genius like Michael Angelo turning his divine intellect to the contemplation of a soil-pipe, we confess that it seems like a "god kissing carrion." But the necessity has arisen; people feel that the most magnificent structure is but a whited sepulchre if sewer air gain access to it, and accordingly the heads of the architectural profession, led by the President of the Institute, Mr. Whichcord, are manfully facing the cruel duty imposed upon them, and we may soon look to having our buildings constructed with all the safeguards which sanitary science has yet suggested. It was not to be expected that architects would yield to sanitary exigencies without grumbling, and accordingly one architect was found to advocate the sending of "waterclosets, pipes, and plumbing of every kind outside the house" (as though such a course were possible in London), and another turned upon the sanitarians with a taunt that the whole of sanitary science was only tentative and experimental, and that it had no claim to be considered exact or finite. We trust not; we do not know of any branch of science which is finite. The word "progress" has a welcome sound in the ears of scientists, and we could only wish that architects were less content to copy Grecian or Venetian models for their houses, and by trying

to adjust antique models to modern requirements, give us at the same time the diseases which depopulated Athens and decimated Europe in the Middle Ages. Alongside of the account of this debate is a verbatim report of a lecture delivered by Mr. Robins to members of building societies, at the Parkes Museum, the subject being ventilation, lighting, and warming. The lecturer, by his frequent quotations from Parkes, De Chaumont, Galton, Corfield, and other writers on the science of hygiene, showed he completely recognised that henceforth those who practise architecture as a fine art must be votaries at the shrine of Hygeia, if their edifices are to be altogether lovely. In addition to the foregoing we find an able editorial article on "the Campaign against Preventable Human Misery," in which the writer, after alluding to the sanitary associations which have lately arisen among us, devotes his attention mainly to the "*burning* question" of smoke prevention, and his remarks are tempered by suggestiveness and sound common sense. In bedrooms and dressing-rooms the writer is of opinion that some of the gas-fires which have already been invented will be found to answer the purpose. In the nursery, in consequence of the absolute necessity of a free supply of fresh air, he advises the retention of the ordinary open grate as we have it at present. In the kitchen the writer thinks that "culm," composed of anthracite-dust welded into balls with the aid of clay, a fuel much used in Pembrokeshire, would prove both smokeless and economical. For the drawing-room fires of the rich, wood or cannel coal should be employed, and this, the writer affirms, "is the very poetry of open fires." He appears to take the view that the main difficulty in the smoke question is to be found in the various domestic hearths, and that the tall chimneys of manufacturers may be reduced to reason without much difficulty.

BOOTS.

THE discomforts of an inclement season are mainly due to having to encounter it in unsuitable clothing, and we believe that the pleasures of out-door exercise are, to the young, enhanced rather than otherwise by boisterous weather, provided the apparel is calculated to resist it. Of all articles of clothing nothing is more important in weather such as we have been lately enduring than the boots, and the quality of these largely affects the power of the individual to avoid the risks attendant upon snow and thaw. A cheap pair of machined boots made of green absorbent leather, and stitched with unwaxed thread, are admirably calculated to eat up the saving in their initial cost with a bill for medical attendance, and it should be remembered that in purchasing boots it is of prime importance to see that the leather is properly tanned and well seasoned, that the threads are waxed and the stitches sufficiently close. At such a time some extra protection for the feet is commonly resorted to, and for those who need an overshoe to keep the feet clean and dry when paying visits of ceremony, there is nothing better than the American overshoes made of cloth and india-rubber, and popularly known on the other side of the Atlantic as "Jemimas." These keep the feet warm as well as dry, and are a great improvement on the old goloshe. To keep the feet warm, however, there is nothing like brisk walking, and overshoes of all kinds are a great hindrance to exercise. How can we get exercise and keep the feet moderately dry as well? That is the problem to be solved. In very bad weather the boots should be greased or dubbed instead of being polished, and it will be found that water will run off upper leathers so treated. The absorbent sole, however, remains, and no matter what thickness of leather be used the sole gets to a certain extent saturated after a long walk in the damp, and the evaporation from a wet sole is the great cause of cold feet when the exercise is finished. It is a great object to keep the absorbent sole out of the damp if possible. To effect this there is no better contrivance than the very homely one of having a few hobnails driven into it, and since these may be quickly applied to any pair of boots, and do not (or need not) materially increase the weight or clumsiness of the boot, we think such a course is strongly to be recommended. The advantages of them are the following:—1. They keep the sole from one-eighth to a quarter of an inch off the damp ground. 2. They give a firm hold on snowy or greasy pavements when locomotion is almost impossible in ordinary boots. 3. They allow the sole to drain of such moisture as it picks up, and by keeping a layer of air beneath the sole and the damp ground they increase the warmth of a boot just as the familiar expedient of a wisp of straw keeps the foot warm when placed inside a boot. 4. They are very cleanly, and by giving fewer points of contact between the sole and the ground they prevent to a great extent the splashing which is caused by the sharp contact of a wide heavy sole with a sloppy pavement. There are undoubtedly disadvantages, the chief of which is the sound; but, on the whole, in damp weather hobnails are a rare luxury, and we believe that those who are tempted to follow our advice will not blame us for devoting a few lines to the hygiene of "clouted shoon."

THE CIRCULATION IN MARROW OF BONE AND CEREBRAL MENINGES.

KOLLMAN, in a series of investigations into the circulation in the medulla of human bone, has corroborated the statements of Hayer and Rindfleisch that this circulation is not continuous through vessels, but that the minute veins open into the interstices of the tissue. In spite of this interruption, the circulation goes on with perfect regularity. Aqueous solutions of Berlin blue find their way from the veins to the arteries as readily as from the arteries to the veins, and, what is still more remarkable, they find their way from the sub-arachnoid space of the spinal cord, to the spongy structure of the skull, into the sinuses of the dura mater, and into the veins of the skull and of the face. It is conjectured that the communication between the sub-arachnoid spaces and the veins is by means of the Pacchionian granulations. The sub-arachnoid and subdural spaces of the brain are not in direct communication, but the injection readily passes from the subdural space into the periphery of the Pacchionian granulations and so into the venous sinuses. There are also fissures in the inner surface of the dura mater which are openings into the lymphatic canals.

THE ROYAL PORTSMOUTH, PORTSEA, AND GOSPORT HOSPITAL.

THIS hospital is passing through a period of some difficulty. The funds are not in a flourishing state, and amongst the remedies proposed is an alteration in the out-patient department. At the recent annual meeting of the governors and friends of the institution it was alleged that many abuses exist, and that many persons get out-patient tickets who are able to pay for medical attendance. It was alleged also that the medical officers were sometimes late or absent in the out-patient department. With a view to meet these evils, it was proposed by the committee to establish a provident dispensary in connexion with the hospital, and at Southsea, and to expend a sum not exceeding £200 annually in remunerating the medical officers who may be appointed to attend the out-patients and the members of the provident dispensary. Further, it was proposed, in order to give effect to the first resolution, to suspend certain rules of the institution affecting the appointment and rights

of the medical men. This proposal came upon the medical men unexpectedly, and was warmly objected to. Dr. Cousins therefore proposed, as an amendment, that the scheme should be examined and reported on by a special committee, to consist of the committee, the honorary medical officers, and eight subscribers, chosen from the members. A long and keen discussion followed. Dr. Cousin's amendment was carried by 16 to 8. We commend the subscribers for listening to the objections of the medical men, and for declining to adopt organic changes without the fullest examination of their merits and tendency. The warning of Guy's should suffice for all lesser institutions. It will be found impossible to work hospitals or dispensaries successfully without the concurrence of the medical staff. To the public of Portsmouth we would venture to say that no cause can be more worthy of their support than that of the hospital, and that no such community can relieve itself of the responsibility of upholding it. After all allowance for questions of management, or even abuse, there remains the great claim of painful and disabling suffering.

SICKNESS AND PAUPERISM.

IT is not only the present discomfort and distress occasioned by the severity of the weather that we have to contend against, but we must look forward to a considerable increase of what we may call unavoidable pauperism. Already the wards of the general hospitals and sick infirmaries of the workhouses are crowded to overflowing. At the same time a decrease is noticed in the attendances at the out-patient room. This is caused partly by the severity of the weather keeping the sufferers at home, but chiefly by the fact that the chronic cases which form so large a proportion of out-patient attendants have given up the struggle, and have been obliged to seek refuge in the workhouse. Amongst our working population there is always a large number suffering from chronic bronchitis, emphysema, and rheumatic affections, and who, if they can tide over the worst months of winter, can during the remainder of the year earn a fair wage and thus keep house and home together. In ordinary winters this is feasible, but with such a prolonged continuance of cold as we are now experiencing the struggle is too often impossible. The savings of the summer months are expended, the sufferer is unable to attend the out-patient room, and the wards of the hospital are too full to receive him; so the workhouse is his only refuge. Once there the chances are that he never ceases to be a burden on the rates. With his fellows outside he knows he has lost caste, and he also feels that the comfort and repose even of a workhouse ward are superior to those he can obtain at home. Feeling, therefore, that his old associates will shun him on account of the taint of pauperism he now bears, and shrinking from what he now thinks to be a useless struggle, he resigns himself to his fate. And so a man, who for years with a little timely assistance during seasons of illness might have supported himself, becomes a burden on the rates. If in becoming a pauper the disaster only concerned himself the mischief would be limited. But under the present system the man pauperises his wife and children. These latter, brought up under the grim shadow of the Poor Law, continue the pauper brood for generations. In this time of exceptional distress the great point to aim at is to prevent respectable families drifting into pauperism. At our great hospitals the claims for admission should be carefully investigated; this is no time for beds to be occupied by well-fed and pampered servants, or by the pensioners of the rich, when a bed may turn the scale between independence and pauperism for a whole family. The charitable, too, should use discrimination as to the institutions on which to bestow their charity; between those which have reserve funds and those which are struggling on from hand to mouth, depending only on daily and weekly subscriptions, and relying on the public to supply any deficiencies that may arise. Such advice might seem superfluous; but only to-day in the columns of a contemporary we saw an appeal from a hospital which possesses a reserve fund of over a hundred thousand pounds, and has land valued at ten thousand, stating that funds were urgently needed! Under the present exceptional circumstances hospitals with such a balance-sheet have no right to appeal to the charitable. To demand money in such a case, when there is so much suffering requiring immediate relief, is positively sinful.

COLLEGE OF PHYSICIANS OF IRELAND.

DURING the months of November and December last a large number of candidates presented themselves for the licence in Medicine of this College, and twenty-three, having satisfied their examiners, were duly admitted licentiates. This month one gentleman only obtained the licence, and the reason of this sudden decrease in the number of applicants is explained by a regulation in reference to fever certificates, adopted by the College in May last, and which came into operation the first day of the present year. By this regulation it is ordained that every candidate for the licence in Medicine shall be required to produce evidence that he has for not less than three months studied fever in a hospital recognised by the College containing fever wards, and recorded from daily personal observation at least five cases of fever to the satisfaction of the attending clinical physician. It seems that this by-law has created a good deal of inconvenience to intending applicants, and hence the falling off in the numbers, and the explanation that so many candidates underwent examination in November and December last before this regulation came into force. We believe, however, that we are correct in stating that any registered practitioner of five years' standing can be admitted, according to Regulation 7 of the College, to examination for the licence on producing his certificate of registration, and showing that he is exempted from producing the fever certificate, as well as from examination by printed questions.

BACTERIA IN THE CHOROID.

THE *Centralblatt für prakt. Augenheilk.* for October last contains a paper by the Duke Charles of Bavaria on the discovery of bacteria in the choroid coat of two eyeballs. The eyeballs, which showed neither naked eye nor microscopical evidence of disease, were preserved in Müller's fluid. On examination the vessels of both the coarser and the finer vascular network of the choroid were found closely packed with bacteria. They were especially abundant in the larger capillaries just before their ultimate division and in the finest capillaries themselves, and least numerous in the small arteries and veins. There was no sign of decomposition of the eyes, nor were any organisms found in the Müller's fluid, in which they had been immersed, while other globes contained in the same vessel did not present any similar appearances. These, together with the fact that the bacteria were only in small numbers in the veins and closely packed in the capillaries, negative the supposition that they had originated post-mortem. The bacteria were cylindrical rodlets about half the length of the nucleus of a leucocyte, with a clearly-defined outline, homogeneous, glistening, and structureless contents. Besides these, some bacilli from five to twenty times their length and some of the small rods undergoing division were found. They mostly resembled the forms of organisms seen in septic diseases and in decomposition, and they differed from the bacilli of splenic fever by their greater thickness and the slight rounding of their ends.

THE TRANSVAAL WAR.

THE Bearer Company of the Army Hospital Corps, commanded by Surgeon-Major William Johnston, under orders for the Cape, was inspected by Surgeon-General Fasson, on the Depôt Parade-ground, South Camp, Aldershot, on Monday last. The men were equipped with the white colonial helmets, and carried Martini-Henry carbines, with which they have been armed in preference to the revolver which was issued to the Army Hospital Corps in the late Zulu War. The Company paraded at an early hour on Tuesday morning, and marched to the Aldershot station, where a special train was in waiting to convey them to Southampton, where they embarked on board the Union Company's mail steamer *Danube*, which sailed for Natal that day. The marching-out strength of the Company was eight officers of the Army Medical Department, three officers of the Army Hospital Corps, two sergeant-majors, and 136 non-commissioned officers and men, with, for transport purposes, one conductor and twenty men of the Army Service Corps. The ambulance waggons, water-carts, surgery waggons, pack-saddles, stretchers, cacolets, litters, and other equipments had been previously sent from Woolwich arsenal and shipped on board the *Danube*. The War Office authorities decided that the horses and mules for the Bearer Company shall be obtained in Natal on arrival, an arrangement which economises the transport from England; but, looking at the known scarcity of baggage animals in the Cape Colony, it is a somewhat hazardous proceeding.

UNIVERSITIES (SCOTLAND) VOTING BILL.

THIS is a Bill introduced by Dr. Lyon Playfair and others, to amend the mode of voting in elections of representatives for the Scottish Universities. The chief provisions of this Bill are to the effect that electors are to vote by voting-papers only, that these papers and letters of intimation are to be issued by the Registrar of the University, and are to be returned by the voter to him, to be kept in safe custody till counted by the returning officer. Signature before a magistrate is to be dispensed with. The candidates are to be bound by Clause 15 to pay the expenses incurred in issuing the voting-papers, and in taking the poll. These arrangements seem calculated to promote the order and keep down the expenses of University elections, and to be worthy of support.

THE MUCOUS MEMBRANE OF THE ANUS.

IN the *Journ. de l'Anat. et Phys.*, G. Hermann has recently published some observations on the structure of the anal mucous membrane. He includes in this term a circular rim from 5 to 12 mm. in depth, reaching from the narrow white ano-cutaneous line pointed out by Hilton, to the ano-rectal line above—a portion corresponding to the internal sphincter and analogous to the red free border of the lips between the skin and true mucous membrane. After pointing out that with the exception of a serous coat on the outside, the structures of this region are the same as those met with in the upper part of the intestine—two layers of muscular tissue, mucous membrane, Auerbach's and Meissner's plexuses,—he enters into fuller detail as to the structure and development of the mucous membrane. The epithelium is squamous and stratified, but columnar in the depressions between the columnæ recti of Morgagni. At the sides he finds pouches and duct-like tubes lined with simple or stratified epithelium, which dip down to the depth of one centimetre into the subjacent muscle and there sometimes branch at their extremities. He considers these to be analogous to the glands found in this situation in animals. It is also suggested that these depressions, duct-like tubes, and the closed follicles found between them play an important part in the production of anal abscess and fistula.

DUBLIN HOSPITAL SUNDAY.

THE total amount obtained by the collections last November for this fund amount to £4050, which shows a decrease of £294, as compared with that of 1879. This decrease was expected, and is undoubtedly to be attributed to the land agitation and the depression in trade, circumstances which sufficiently explain the falling off in the receipts. Each charity which participates in the funds collected is assisted (1) according to the amount of voluntary contributions received by it, and (2) by the amount of work done. Among the donations was one which may be specially referred to—viz., a sum of nearly £40, being the proceeds of a football match, played by the Irish Football Union in November last.

THE ROYAL MATERNITY CHARITY.

THE annual report of this charity for delivering poor married women at their own houses is published. The institution is 124 years old. The committee report that 3595 females have been delivered in the year, the largest number since 1867. There were but eight deaths and few other serious results. The work is done chiefly by midwives, with the assistance of the medical officers in emergencies. The results compare very favourably with those of lying-in hospitals. It is significant that, notwithstanding the generally bad hygienic condition of the houses of the poor, and all the hard conditions of poverty itself, the process of parturition should be so much more favourable in such houses than in lying-in hospitals, however well conducted.

THE DEATH OF DR. ANDREW WOOD.

IT is with extreme regret that we announce to our readers the death of Dr. Andrew Wood of Edinburgh. It occurred suddenly on Tuesday. He had been ailing for some days, but on that day resumed his professional duties. On returning from his round, he was found in his carriage lying in a state of unconsciousness, from which he did not recover. The deceased gentleman was seventy years of age. We are compelled to reserve a further notice of this melancholy event and of Dr. Wood's life till next week.

LEGACIES AND THE HOSPITAL SUNDAY FUND.

THE Hospital Sunday Fund was wise in publishing a form of legacy for the use of those wishing to use the Council of the Fund as a medium for the distribution of their legacies to Hospitals. A cheque was received at the Mansion House a few days ago for 100 guineas from the trustees of the late Mr. James Drew, of Cornwall-terrace, Regent's-park.

SUPPURATION OF ENLARGED THYROID.

SPONTANEOUS suppuration of a goitre is one of the least common terminations. An instance in which this occurred during the course of an attack of typhoid fever has lately been recorded by M. Weill, from Jaccoud's wards. The patient was a man aged twenty-two, who had a goitre of moderate size and firm consistence. He had lived until within four months in a district where goitre is endemic. The attack of typhoid fever ran a normal and mild course. The day after the temperature had become natural, he complained of severe pain in the neck, and the surface of the goitre was observed to be reddened. During the next day the redness and size of the goitre increased, and its consistence diminished, until distinct fluctuation was perceptible. A week later it was incised, and a large quantity

of pus escaped. A drainage-tube was applied, and the cavity washed out daily with carbolic acid. It gradually lessened in size, and was ultimately reduced to two or three small nodules by the side of the larynx.

CLINICAL SOCIETY.

THE newly elected President, Mr. Lister, will take the chair for the first time at the meeting of the Clinical Society this evening (Friday), and will deliver an introductory address, before the ordinary business of the Society is proceeded with. Mr. Lister will take for his subject, "the Catgut Ligature," and a discussion will probably follow.

TWO warders of the Menyflatts Lunatic Asylum are in custody in connexion with an alleged fatal assault on an inmate, Cornelius O'Leary. The patient, for nearly three weeks before his death, was very violent and needed constant attention night and day. On the morning of the 3rd inst., it was pointed out to Dr. Liddell at his usual morning visit, that there was something wrong with O'Leary's chest, and on examination it was found that at least one of his ribs was broken. In two days more the patient died, and the post-mortem examination, we understand, tended to confirm Dr. Liddell's suspicion that the injury was not self-inflicted. The two attendants, who are night warders and who were with O'Leary the night before the injury was discovered, have been before the Sheriff and were committed for further inquiry.

THE subscribers to the "Habershon and Cooper Forster Testimonial Fund" are already numerous, and it is not intended to delay the presentation for any length of time. We have been asked to state that the list will be closed on Feb. 28th. Guy's men who wish to subscribe will therefore do well to communicate at once with the Treasurer, C. A. Aikin, 7, Clifton-place, Sussex-square, W.; or with one of the Secretaries—H. Morris, 2, Mansfield-street, Portland-place, W., or F. Durham, 38, Brook-street, Grosvenor-square, W.

AT the meeting of the Epidemiological Society on Wednesday, Feb. 2nd, at 8 P.M., Dr. Squire will read a hitherto unpublished letter by Dr. Edward Jenner, containing "Instructions for Vaccine Inoculation," in the possession of Mr. Symonds, F.R.C.S., of Oxford. Surgeon-General Gordon will afterwards introduce the subject of Cholera and Fever, especially with reference to their occurrence in India and China.

MR. ERNEST CRAVEN LUNN, L.S.A., whose name appears this week in the list of gentlemen who obtained the Membership of the College of Surgeons on the 20th inst., whilst waiting at the doors of the Gaiety Theatre with a young lady, whom he was about to marry, was knocked down by a cab, and instantly killed; his betrothed at the same time sustaining a fracture of one of her legs.

A CONFERENCE of anatomical teachers will be held next Thursday evening (Feb. 3rd) at the Middlesex Hospital to consider the propriety of taking steps to remedy the prevailing scarcity of subjects for dissection.

AT the meeting of the Quekett Microscopical Club this evening (Friday) Dr. Cobbold will read a further communication from Dr. Manson, of Amoy, on Filaria.

DR. J. J. LUCE, the accident to whom we recorded on the 1st inst., is, we are glad to learn, recovering from the serious injuries he received by being thrown from his vehicle.

WE may remind our readers that at the meeting of the Pathological Society to be held on Tuesday next the President (Dr. Wilks) will deliver his introductory address, which was postponed from the last meeting on account of the severe weather having caused only a very small attendance of members.

JOHN HOUSLEY, M.D., and E. M. C. HOOKER, L.R.C.P. Lond., M.R.C.S. Eng., are candidates for the vacant Coronership of East Retford, Nottinghamshire, and have each issued an address to the freeholders.

New Inventions.

NEW POCKET MICROSCOPE.

WE have received from Messrs. Salt and Son, surgical instrument makers, Birmingham, a small pocket microscope for the examination of urinary deposits, blood, &c. The stand and mirror hitherto deemed essential in all compound microscopes are dispensed with. A lens is placed at the end of the microscope, which, when the instrument is held up to a window or lamp, concentrates sufficient light upon the slide to render all objects in the field distinctly visible. Even on a dull day in London we have found the illumination thus obtained amply sufficient. The microscope is a compound achromatic one, furnished with a quarter inch objective, having a magnifying power of 120 diameters, and a sliding tube of short range, for adjusting the focus. In

using the instrument it is intended that a few drops of the suspected urine are placed between two small glass slides, which are then placed in a deep notch in the lower part of the microscope. They are fixed *in situ* by a sliding tube with a milled flange, which, when pushed up against the glass, holds it securely. The microscope is then applied to the eye, as shown in the engraving, and the focus adjusted.

It is an ingenious little instrument, very compact, measuring only five inches in length, and its case is scarcely bigger than that of a fair-sized urinometer. We can thoroughly commend it not only for convenience, but, when properly used, for efficiency also. It is well adapted

for the examination of the blood; an excess of white corpuscles can be at once distinguished by its means. It is also, when properly employed, very useful for the examination of the urine, but used in the method recommended by Messrs. Salt, it is almost valueless for this purpose. It is true that if a urine were loaded with pus, this could no doubt be readily discovered in the manner above described; but if the urine contained a few blood-corpuscles or casts, they could not be thus discovered. The film of liquid held between two glass slides by capillary attraction is so extremely thin that objects sparingly contained in the urine would not be discovered. If, however, a small cover glass be used, and the movable tube be placed above the slide so as to clamp it from above instead of from below, and thus avoid pressing the cover glass against the edge of the notch, a thicker film of liquid is examined, and the instrument answers very well. But its utility would be greatly increased if a plain mirror were fixed in a removable tube at the end of the instrument, so that it could be used in the upright posture as well as, if desired, in the horizontal. All practitioners know how desirable it often is, in examining a urinary deposit, to have a very thick film of liquid, and this is impossible unless the microscope is vertical in position.

INSTRUMENT FOR APPLICATION OF WOOL &c. TO CAVITIES.

MESSRS. MAW, SON, AND THOMPSON have sent us a new instrument manufactured by them for the application of cotton-wool, &c. to the bottom of cavities or sinuses. It is a stout probe nine inches long, terminating at one end in two sharp prongs, which are spirally twisted. By this end cotton-wool is firmly held, and can be used to cleanse the bottom of sinuses or cavities, or, if desired, by rotating the probe in the opposite direction to the spiral, the cotton-wool is left at the bottom of the cavity. Surgeons will find it to be of use in many ways.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

THE METROPOLITAN SMALL-POX HOSPITALS AS FOCI OF INFECTION.

A LETTER, of which we subjoin a copy, is being very extensively circulated amongst medical practitioners in and about Fulham, Kensington, and Chelsea, by Dr. Thorne Thorne of the Local Government Board. The matter to which it relates is one of so much importance that we trust every one concerned will promptly comply with the request which is made.

"Local Government Board, Whitehall, Jan. 10th, 1881.

"DEAR SIR,—Under the instructions of the Local Government Board I am engaged in an inquiry relating to the use and influence of hospitals for infectious diseases, and in connexion with this investigation I am desirous of ascertaining whether such hospitals are, and if so by what means, instrumental in causing the spread of infection in the localities in which they are situated.

"At the present moment I am engaged, together with my colleague, Mr. W. H. Power, in procuring information on this point as regards the Metropolitan Asylums District Hospital at Fulham, where cases of small-pox are under treatment, and I shall feel much indebted to you if you will kindly give me the names and addresses of any persons whom you may have met with suffering from small-pox within a radius of one mile of the hospital since Christmas day last; and also if you will during the next three months give me similar information as regards any cases which may come under your notice, quite irrespective of any presumed source of contagion.

"I need hardly say that any such information will in every case be used with due regard for your own and the patient's desire for privacy.

"I am, dear Sir, very faithfully yours,

"R. THORNE THORNE."

THE DISSEMINATION OF INFECTIOUS DISEASE.

Here are some illustrations of modes in which infectious diseases are thoughtlessly disseminated. Dr. Sedgwick Saunders reports that the body of a child who had died of scarlet fever was removed from a house in Kensington to an undertaker's in the City, and kept on his premises unburied from Dec. 30th to Jan. 1st. It is reported that the corpse of a man dying of small-pox in London was carried to Cottenham in Cambridgeshire for interment. There the coffin was opened for the relatives and friends to view the deceased. As many as a hundred persons viewed the corpse, some even kissing it. Two of the relatives, it is known, subsequently were seized with small-pox and one has died. Inquiry is to be made by the Sanitary Authority (St. Ives) into the circumstances of the case and as to the extent of the mischief arising from it. The *Bucks Herald* records the following:—Scarlet fever attacks a child in a family of several children in London. The medical man recommends that the seemingly unaffected children (two) should be sent away. They were sent to an aunt in Buckinghamshire. On the evening of their arrival one was found to have the eruption of scarlet fever out upon him, the other sickened the next day. The first attacked died and an inquest was held on the body. We have still to learn whether these cases have proved the focus for a new extension of the disease.

ST. VEDAST'S CHURCH (CITY OF LONDON).

Dr. Sedgwick Saunders has presented a report to the City (of London) Commissioners of Sewers, which gives a curious account of the condition of the burial-places of the dead within this old structure. It appears that in process of time, from the deterioration of the structure of the vaults beneath the flooring of the church, the walls have yielded and cracked, the floor above also yielding, and the cracks extending through the floor into the body of the church. On an investigation of the state of the church in this respect it was found that certain builders were no better long ago than they are now, and that vaults which should have been "sealed" had not been sealed, and had been simply covered in, and even floored by old gravestones. An instance is mentioned of the wooden floor of a pew being found as constituting the only covering of a grave which contained five coffins. The congregation of the church had unwittingly for years been copying the habit of the monkish order, who are accustomed to preserve their dead and pray among them; but, unlike this order, without the corpses having undergone a previous desiccation. The Commissioners of Sewers have now taken the matter in hand with a view to secure a more decent and wholesome condition of the church.

THE POPLAR INFECTIOUS DISEASES HOSPITAL.

A deputation of the Metropolitan Asylums Board has visited and inspected this hospital, but the visit has tended to confirm the objections of the Board to either hiring or purchasing the building. Indeed, the deputation have reported somewhat disparagingly of it, averring that although the accommodation is said to have been erected for seventy-two patients, in reality it is only sufficient for forty-eight; and, in addition, they assert that the arrangements for the executive are deficient. For example, room is wanting for lodging servants. The Poplar District Board thought it bad enough for the Asylums Board to refuse to come to terms with them, but for the latter to depreciate the hospital, a brand-new one built at a considerable cost, is more than District Board nature can bear; so a "representation" is to be made to the Asylums Board concerning the injurious remarks of the deputation.

THE RURAL SANITARY AUTHORITY OF GUILDFORD.

We are glad to learn that the Rural Sanitary Authority of Guildford have decided that it is no longer desirable that the medical officers for the Union be reappointed medical officers of health, but that one medical officer of health who is not in private practice be appointed. We trust the Authority will further see the advantage of entering into the Surrey Combination of sanitary districts for the appointment

of a medical officer of health. The evidence in favour of combined districts for such appointment would appear from the latest report of the Local Government Board to be almost overwhelming, and Guildford is so situated with respect to the Chertsey Union, Dorking Union, &c., as to appear to fall naturally into combination with them. We have little doubt that this view of the subject will receive the full consideration of the Authority.

The vaccination officer of Bethnal-green has asked his Board of Guardians for assistance to make a house-to-house visitation of his district, small-pox being still on the increase there. One member thought the request to be much too serious to settle offhand, and that it should be referred to the Dispensary Committee. Another thought that this talk about small-pox was "sheer nonsense." The disease was "simply nature righting herself." A third thought twenty assistants would be needed to do the work thoroughly which the vaccination officer wanted to be done (not seeing that the statement was a confession of the backward state of vaccination in the parish). A fourth thought that it would be unwise "to employ such a large staff without due consideration." So (the Local Government Board's advice notwithstanding) the Board of Guardians will pause to consider a question which ought to have been "considered" months ago, while small-pox steadily gains ground.

Dr. Bridges has been complaining to the Local Government Board of the physical condition of certain children in St. Olave's Workhouse. The Local Government Board transmitted Dr. Bridges' observations to the Board of Guardians. In their discussion of these observations, the Chairman of the guardians observed that the questions raised by Dr. Bridges had been considered by the visiting committee, and the statement with respect to insufficient dietary only related to a few of the elder children. Whereupon a Guardian observed that doubtless by the summer time St. John's churchyard would be in a condition to be used by the children. Does this mean for burial or for exercise?

An evening contemporary announces that, on the recommendation of the Metropolitan Asylums Board, the visiting of relatives and friends to the inmates of the metropolitan workhouse district schools and orphanages in connexion with the Poor-law administration has been prohibited in consequence of small-pox in the metropolis. Does this imply that the Metropolitan Asylums Board distrust the protective power of vaccination, or that the children in the orphanages and schools are imperfectly vaccinated? We commend the question to the attention of the Local Government Board.

We understand that the St. George's-in-the-East Vestry, as Sanitary Authority, has felt called upon to require the Blackwall Railway Company to *clean* its station at Shadwell, the persistent dirtiness of the stations on this line of railway not hitherto having been interfered with. The Company are aghast at this astounding interference with a right of uncleanliness which they had reason to believe had become vested by long immunity.

On a question of giving additional remuneration to the relieving officers for extra services in connexion with the vaccination work of the Union, before the Stepney Board of Guardians, several members spoke in forcible terms of the neglect of vaccination in the Union, and of the vaccination work of the guardians having been suffered to fall into arrear.

The Crewe magistrates have imposed a fine of £4 on a pork-butcher for keeping his premises in an uncleanly state, surreptitiously passing offal into the drains of his slaughter-house, not having provided proper receptacles for it.

The Court of Chancery has refused to enforce the specific performance of certain contracts for the purchase of dwelling-houses in which the drainage was found to be defective.

The report of a serious outbreak of scarlet fever having occurred in the neighbourhood of Lincoln is, we understand, incorrect.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

The effect of the severe cold which set in on 12th inst. caused a marked increase in the registered mortality last week, although the increase was scarcely so great as might have been expected to result from the exceptionally low temperature recorded. In twenty of the largest English towns, estimated to contain in the middle of this year a population exceeding seven and a half millions of persons, 4582 births and 4199 deaths were registered last week. The births were 604 below, whereas the deaths exceeded by no less than 904, the average weekly numbers during last year. The deaths showed a further increase of 755 upon the low numbers returned in recent weeks. The annual death-rate, which had been equal to 21·3 and 23·6 in the two preceding weeks, further rose last week to 28·8, a higher rate than has prevailed in any week since the first week in February last, when it was equal to 37·0. During the past three weeks of the current quarter the death-rate in these twenty towns averaged 24·6 per 1000, and was 0·9 below the average rate in the corresponding periods of the five years 1876-80.

The deaths referred in the twenty towns to the principal zymotic diseases, which had been 401 and 383 in the two preceding weeks, were 390 last week, and included 103 from scarlet fever, 93 from whooping-cough, and 72 from measles. The annual death-rate from the principal zymotic diseases averaged 2·7 per 1000 in the twenty towns, among which it ranged from 0·7 and 1·0 in Wolverhampton and Hull, to 3·6 and 4·0 in Norwich and Salford. Scarlet fever showed the largest proportional fatality in Norwich and Sunderland, whooping-cough in Leeds and Nottingham, and measles in Salford. The deaths referred to fever (principally enteric) in the twenty towns, which had been but 39 and 35 in the two previous weeks, further declined to 32 last week, and were very considerably below the average. Nine of the 13 deaths from diphtheria occurred in London. Small-pox caused 44 more deaths in London and its suburbs, whereas no fatal case of this disease was registered in any of the nineteen large provincial towns. The number of small-pox patients under treatment in the Metropolitan Asylum Hospitals, which had steadily increased from 77 to 477 in the twelve preceding weeks, further rose to 516 on Saturday last. The new cases of small-pox admitted to these hospitals, which had been 85 and 118 in the two preceding weeks, further rose to 142 last week. The Highgate Small-pox Hospital contained 27 patients on Saturday last, against 24 and 26 in the two previous weeks.

The deaths referred to diseases of the respiratory organs in London, which had slowly increased from 290 to 371 in the four preceding weeks, rose last week, under the influence of the severe cold, to 617, and showed an excess of 141 upon the corrected average number in the corresponding week of the last ten years; 441 were referred to bronchitis, and 97 to pneumonia. The annual death-rate from lung diseases (excluding phthisis) was equal to 8·7 per 1000 in London, while the rate from the same diseases was 14·2 in Liverpool.

In the twenty towns last week the causes of 114 deaths were not certified, either by a registered medical practitioner or by a coroner; these were equal to 2·7 per cent. of the total deaths. The proportion of uncertified deaths was equal to 1·8 per cent. in London, while it averaged 3·6 per cent. in the nineteen provincial towns. The proportion of uncertified deaths was largest last week in Salford, Sheffield, Bradford, and Hull.

HEALTH OF SCOTCH TOWNS.

In eight of the largest Scotch towns, having an estimated population of rather more than a million and a quarter persons, the annual death-rate averaged 31·1 per 1000 last week, against 22·5, 25·9, and 24·6 in the three preceding weeks; this rate exceeded by 2·3 per 1000 the average rate last week in the twenty large English towns. The rates in the eight Scotch towns ranged from 21·4 and 27·2 in Edinburgh and Aberdeen, to 35·5 and 38·1 in Glasgow and Paisley. The deaths referred to the principal zymotic diseases in the eight towns, which had been 105 and 102 in the two preceding weeks, were 107 last week, and were equal to an annual rate of 4·2 per 1000, against 2·7 in the twenty large English towns. In the eight Scotch towns the zymotic death-rate last week ranged from 2·1 and 3·0 in Paisley and Aberdeen, to 4·7 and 6·9 in Edinburgh and Leith. The fatal cases of scarlet fever in the eight towns, which had been 27 and 19 in the two previous weeks, were 28 last week, of which 10 occurred in Edinburgh, 10 in Glasgow, and 6 in Leith. The 25 deaths from whooping-cough showed an increase of two upon the number in the previous week, and included 15 in Glasgow, 5 in Edinburgh, and 4 in Dundee. Of the 19 deaths from diphtheria 12 were returned in Glasgow, as were

8 of the 12 fatal cases of measles in the eight towns. The 8 deaths referred to "fever" showed a decline of 7 from the number in the previous week; 2 occurred in Glasgow, 2 in Edinburgh, and 2 in Greenock. The deaths referred to acute diseases of the lungs (bronchitis, pneumonia, and pleurisy), in the eight Scotch towns were 307 last week, against 161 and 191 in the two previous weeks; they were equal to an annual rate of 12·2 per 1000 of the population; the death-rate from the same diseases in London did not exceed 7·6. The greatest fatality from lung diseases in the Scotch towns occurred last week in Glasgow, Dundee, and Paisley.

HEALTH OF DUBLIN.

The rate of mortality in Dublin showed a further increase last week. The annual rate of mortality from all causes in the city, which had been equal to 31·8 and 35·1 in the two preceding weeks, further rose last week to 45·7, a higher rate than has prevailed since the end of January last. During the first three weeks of the current quarter the death-rate in the city averaged 37·5 per 1000, against 24·1 in London and 23·2 in Edinburgh. The 292 deaths in Dublin last week showed a further increase of no less than 68 upon the numbers returned in the two preceding weeks, and included 37, or nearly 13 per cent., which were referred to the principal zymotic diseases; against but 12 in the previous week. These 37 zymotic deaths in Dublin last week included 17 which were referred to fever (typhus, enteric or typhoid, and simple continued), 8 fatal cases of whooping-cough, 6 of scarlet fever, 3 of diphtheria, and one each of small-pox, measles, and diarrhœa. The annual death-rate from these zymotic diseases was equal to 5·8 per 1000 in Dublin last week, while it did not exceed 2·9 in London, and was 4·7 in Edinburgh. The deaths referred to fever in Dublin, which were 13 and 8 in the two previous weeks, rose to 17 last week, and were equal to an annual death-rate more than twelve times as high as the average rate from the same causes last week in the twenty large English towns. The eight deaths from whooping-cough also showed a marked excess upon recent weekly numbers, and the deaths from scarlet fever were within one of those returned in each of the two previous weeks. The deaths of infants were more numerous, but the largest proportional increase occurred among elderly persons; the deaths of persons aged upwards of sixty years, which had been 47 and 66 in the two previous weeks, further rose to 84 last week.

VITAL STATISTICS OF THE ISLE OF MAN.

Civil registration in the Isle of Man was, by recent legislation, nearly assimilated to that which has long prevailed in the rest of the United Kingdom, and the figures for the year 1879 for the first time afforded facilities for comparison and estimation of sanitary condition. The Isle of Man has an area nearly half as large again as that of Rutlandshire, and had in 1871 a population of 54,042, more than twice the population of that county; assuming that the population of the island since 1871 has increased at the same rate as that which prevailed between 1861 and 1871, the present population may be estimated at 55,653. During the year 1879 the births and deaths registered within the island were, respectively, 1569 and 1122, calculated upon the estimated population in the middle of 1879, the birth-rate was equal to 28·3, and the death-rate to 20·2 per 1000 persons living. The marriage rate was equal to 12·4 per 1000. Both the marriage and birth-rates were below the average rates in agricultural counties in England. It may be noted that 7·2 per cent. of the births registered were those of illegitimate children. The death-rate in the Isle of Man differed but slightly from the average rate in England and Wales in 1879, which was 20·9 per 1000. The fatality from the principal zymotic diseases, however, was remarkably small in the Isle of Man, as only 39 deaths in 1879 were referred to measles, scarlet fever, diphtheria, whooping-cough, enteric fever, and diarrhœa, and none to small-pox, typhus, or simple and undefined fever. The annual death-rate from these principal zymotic diseases in the Isle of Man during 1879 did not exceed 0·7 per 1000, against 2·4 in England and Wales. The low rate of infant mortality in the island also affords satisfactory evidence of its sanitary condition; the proportion of deaths under one year of age to births registered in 1879 was not quite equal to 105 per 1000, whereas the average proportion in England and Wales was 136 per 1000. One unsatisfactory feature in the figures for the year may be noted, and this is a high rate of puerperal fatality. We have said that 1569 births were registered in the island during 1879, and it appears that sixteen deaths occurred in childbirth, including five from puerperal fever; these show a rate of puerperal fatality equal to 10·2 per 1000 children born alive. In England and Wales the average proportion of deaths of mothers to 1000 children born alive did not exceed 3·8 during the three years 1877–8–9. It may be hoped that the rate of puerperal fatality in the Isle of Man during 1879 was exceptional. As the death-rate from zymotic diseases in the Isle of Man was so much below, and the rate from all causes differed so little from the rates in England and Wales, it follows that an excess must have occurred from some other causes; but from what diseases this excess mainly arose does not appear from the return before us. It may be noted, however, that the death-rate from phthisis and from acute diseases of the respiratory organs was equal to 3·4 and 3·1 per 1000 of the estimated population; both these rates were in excess of the average English rates from the same diseases. These statistics, if continued annually, will afford the best possible test of the varying sanitary condition of the Manx population.

HEALTH MATTERS GENERALLY AT HOME AND ABROAD.

DIPHTHERIA.

The continued attention which is being given by medical officers of health to diphtheria is interestingly indicated by two communications which have recently reached us. The one is an inaugural address delivered before the Birmingham and Midland Society of Medical Officers of Health by Mr. G. H. Fosbroke, medical officer of health for the urban and rural sanitary districts of Stratford-on-Avon, Evesham, and Alcester, President of the Association; the other contains brief "Notes on the Spread of Diphtheria," printed for private circulation by Dr. Edwyn Slade-King, medical officer of health for Torrington, Ilfracombe, and Dulverton. Mr. Fosbroke devoted his address chiefly to an account of the experiences he had had of diphtheria in his district, comparing these experiences with those of other persons with reference to the disease, and laying particular stress upon the greater prevalence of the malady in rural as compared with urban districts, its association with typhoid fever and with scarlet fever, which he holds to be much closer than is commonly believed, and its inaptitude, as he thinks, to extend in towns as contrasted with the country. Further, he expressed himself as having been unable to trace any definite relations between the prevalence of the disease and the geological formation of a locality, or between the fluctuations of the malady in a district where it was long prevalent and season; he commented on family susceptibility as a predisposing cause, and finally confessed that he had felt himself compelled to admit the spontaneous origin of the disease in certain cases. Dr. Slade-King holds the opinion that "the atmosphere becomes contaminated by contagia from the bodies of the sick [of diphtheria], and that currents of air carry the poison with them in their course"; and he relates several very curious and instructive outbreaks of the disease within his district of particular interest to the student of diphtheria.

SCARLET FEVER AT ROSENEATH AND CLYNDER.

An alarming outbreak of scarlet fever has taken place at Roseneath and Clynder, on the shores of the Gareloch. Many of the cases are serious, and several deaths have already been reported. The drainage of the whole district is extremely unsatisfactory; between the Glasgow sewage mud, brought down and deposited with each tide, and the local sewage, which is discharged usually between high and low-water marks, this locality, which was and is still a favourite summer retreat, is fast becoming unbearable. It is now difficult to find on the shores of the loch a clean spot for bathing; while the local smells and the frequent endemic prevalence of "influenza" are scaring off summer visitors. It is said, however, that the authorities are arranging a complete drainage system for the district, under the guidance of Dr. Yair. Perhaps this epidemic may give an impetus to their efforts. In connexion with this matter, the Rev. Dr. Story, at the close of a recent Sunday service, addressed some plain and sensible observations to his con-

gregation. While regretting the distress prevailing in the parish, he advised the people not to give way to a feeling of panic, but to do all in their power to avert the threatened evil from themselves and their families. He counselled them to keep their houses clean both inside and outside, to clothe their children as warmly as possible, and to give them plain wholesome food, and no trash.

THE MANCHESTER AND SALFORD SANITARY ASSOCIATION.

The annual meeting of this Association was held on the 18th inst., the Bishop of Manchester presiding. We regret to see that the financial condition of the society is still not so prosperous as it should be in so wealthy a city as Manchester. It is a poor return for the benefits that this society has conferred upon the borough, and upon the sister borough of Salford, in keeping public attention alive to the importance of public-health questions, that it should be straitened for funds. A want of just recognition of the educational influence exercised by the Association in matters of health is here implied which is somewhat dispiriting. We also regret to see that from the increasing difficulties the Association has experienced in collecting records of sickness the weekly returns it has issued for twenty years have now to be given up. Considerable attention was devoted during the meeting to the excellent educational work of the Ladies' Branch of the Association.

Dr. Russell of Glasgow reports the occurrence of twelve cases of typhus among persons who had attended the "wake" of a man who had died of the disease in his own residence.

THE SERVICES.

Surgeon-Major R. W. Davies, Army Medical Department, has been appointed surgeon on the personal staff of Sir Donald Stewart, G.C.B., the new Commander-in-Chief in India.

Surgeon-Major James Hector, M.B., has been appointed to the medical charge of the 13th Hussars at Candahar.

Surgeon Henry Bradford, A.M.D., has been appointed Instructor of the Army Hospital Corps, Aldershot, vice Surgeon-Major T. Faris, who has proceeded on service to Natal.

ADMIRALTY.—The following appointments have been made:—Staff-Surgeon C. Harvey to the *Triumph*, for Esquimalt, sick quarters, vice Sharood; Surgeon H. B. Guppy to the *Ganges*, vice Fisher.

THE CASE OF LOUISA MORGAN

(GUY'S HOSPITAL).

THE following is the "Clinical Report" of this case, to which reference was made in the proceedings.

Ward and No. of bed: Mary, No. 2. Nature of case: Old and quiescent phthisis; suppurating cyst in broad ligaments; acute inflammatory mass (tubercular) in cortex of brain. Result: Death; tubercular meningitis. Name and age of patient: Louisa Morgan; aged twenty-six. Residence: 42, Charlotte-street, Old Kent-road. Date of discharge: Died July 21st, 1880.

Physician: Dr. Pavy. Clinical clerk: J. R. Veitch. Date of admission: June 9th, 1880.

Occupation.—Has been in the habit of working the sewing-machine. Is married; has been married ten years; has one child nine years old; never had a miscarriage.

Family history.—Parents both dead. Father was between fifty and sixty when he died. Does not know what he died of. Mother died of brain trouble, aged fifty. No history of phthisis in the family.

Personal history.—Had scarlet fever and measles when a baby. Seven years ago had gastric fever, for which she had medical advice for nearly two months. Has always had a slight cough in winter, but the last winter it was much worse than usual. Has lived regularly; accustomed to take beer and sometimes spirits with her meals. Ten years ago suffered very much from rheumatism in her arms and shoulders principally; was unable to use her arms without great difficulty. Does not remember any particulars of her illness.

Present illness.—Last September had great pain in the lower part of the abdomen; also great pain in her back and loins; was unable to take her food, but suffered from continual thirst. When she drank much she immediately suffered from diarrhœa, with great pain, and passed very light motions. The pain extended down her left thigh; was attended by Dr. Palmer for four months. She remained in bed for about a month, and then began to get about a little each day, but not for any length at a time on account of pain in her stomach and back. She got very much better, and remained so until February, 1880, when she was again taken ill. Was advised to come into the hospital. Three weeks ago her feet and legs began to swell from the ankle to the knee. The diarrhœa was bad, and she suffered from pain in her stomach and back.

Personal appearance.—Thin, delicate-looking, anæmic; complexion light; anxious expression; eyes light, pupil contracted; skin thin, hot, and moist.

Alimentary system.—Tongue clean; appetite bad; complains of great thirst, nausea, and sickness; motions not regular, and very light in colour.

Circulatory system.—Normal.

Respiratory.—There is slight bronchial breathing at the left apex.

June 9th.—Chop.—11th: Evening temperature, 100·4° F. Patient complains of severe headache; her breathing is regular and easy. Takes her food well. Bowels lax.—12th: Evening temperature 99·8°.—14th: Milk O. ½, soda water, and six ounces of wine; ferri am. cit., gr. 5; tinct. sumbul, min. 20; mist. am., ℥1; t.d.s.—16th: Still complains of headache; says it is worse after taking her medicine. A harsh sound is heard at the left apex. Appetite is not so good to-day; tongue rather furred, whitish-brown. Bowels open.—20th: Headache is rather less than it was, but still complains slightly.—25th: Headaches have left her, but she complains of pains in her back and loins; has a leucorrhœal discharge; takes her food well; pulse strong; breathing just the same as before; the bronchial breathing is still heard just below the angle of the scapula (left).—30th: Patient still the same; no headache, but pain in the back and loins. Discharge still continues.

[Note by the Registrar for July 5th.]—I saw her about two hours after bath. At first sight I thought her moribund. She was utterly collapsed, blue and cold. She took no notice of anything about her, and would not answer questions.—F. A. M.

July 6th.—Patient is much worse this morning. Yesterday had a very prolonged bath, almost cold water; remained in it for a considerable time; appears to have suffered from a severe mental shock. (Dr. Pavy.) There was considerable bruising over left shin, and several slight bruises on both arms.—7th: Patient still in same condition. Does not care to answer questions. Tongue furred, brownish colour; face much flushed. There is a nervous twitching at the bedclothes. Passes everything under her. Evening temperature 100·8°; pulse 120.—8th: Morning temperature 99·4°; evening temperature 101·4°.—9th: Still the same objection to speaking; lies quite still except for the twitching of the hands. Takes her food well when she is fed. Morning temperature 100·2°; evening temperature 101·2°; pulse 116; respiration 40.—11th: Morning temperature 99·2°; pulse 100; respiration 38; evening temperature 101·6°; pulse 120; respiration 40.—12th.—Slight bronchial breathing still heard at left apex, just below left of scapula. Does not answer questions; refuses to put out her tongue. Skin very hot, moist. Cheeks much flushed. Passes everything under her. Morning temperature 102·4°; evening temperature 102·6°; respiration 36; pulse 130.—13th: Mist. chinchon. co., ℥1, t.d.s. Morning temperature 102·4°; pulse 140; respiration 38; evening temperature 104° (10 P.M.); pulse 150; respiration 48.—14th: Enema saponis stet. Morning temperature 103·6°; evening temperature 102·4°; pulse 140; respiration 32.—15th: Still the same; temperature very high; appears hardly sensible; P. enema. Morning temperature 102·4°; evening temperature 103·2°.—16th: Glyc. boracis. Morning temperature 101·4°; pulse 150; evening temperature 103·2°; pulse 150.—17th: Patient still lying in a semi-conscious state; will not take food unless put into her mouth. Morning temperature 103·2°; evening temperature 102·6°; pulse 140.—18th: Morning temperature 102·6°; pulse 140; respiration 40.—19th: There is bronchial breathing at apex of right scapula; patient still in same condition. Morning temperature 104°; evening tem

perature 104°; pulse 146.—20th: Patient perfectly unconscious; appears to suffer acute pain when left arm is lifted in taking temperature; swallows with difficulty. Morning temperature 105°; evening temperature 104·7°; pulse 200; respiration 60.—21st: Morning temperature 105°; pulse 200; temperature 106° (2 P.M.)—22nd: Patient died at 11.30 last night. Post-mortem examination to-day.

The following is a summary of Dr. Goodhart's notes of the post-mortem examination:—

Post-mortem.—The convolutions of the right hemisphere along the longitudinal fissure, about the hinder part of the first frontal and the anterior central, were involved in a large mass of yellow tubercles, which dipped some way into the white matter of the cerebrum. The section of it was of an unusual appearance, being softer than usual and many-coloured, from changes in the blood pigment within and around it. At first sight it was not unlike a mass of red softening. But a more careful examination showed that it was a focus of yellow tubercle, in which other secondary changes, softening, and decomposition, or disintegration of blood had occurred. Behind this large mass was a second smaller one, also in the convolutions, bordering the longitudinal fissure, and having the usual fine yellow characters of yellow tubercle. In addition to these, the convolutions about them had a diffused layer of yellow tubercle uniting their edges, and spreading into the pia mater over them, while at the base there was a general tubercular meningitis. It was my opinion at the time that there had been a quiescent or slowly-maturing growth of yellow tubercle, probably existant for some time, and that the softening and tubercular meningitis were of recent date.

Correspondence.

"Audi alteram partem."

THE FELLOWSHIP OF THE ROYAL COLLEGE OF SURGEONS, EDINBURGH.

To the Editor of THE LANCET.

SIR,—As a licentiate of the above College I have been extremely pleased with the letters in your journal. At the same time I must say that it is somewhat extreme to designate the Fellowship of this college as a *bogus* diploma. No one can obtain it who has not passed an examination in surgery previously. You might as well say that the M.D. degrees of St. Andrews and Aberdeen are bogus degrees; still, I think no one will be bold enough to assert this. These degrees are given by promotion, after the M.B. has been two years in practice, which really means nothing, for a practitioner may be unfortunate enough to see very little practice in two years, or, may be, he practises homœopathy during that period. Edinburgh and Glasgow have only insisted on a *thesis* for the degree during the last few years, and a few years ago it was very seldom a thesis was rejected. It must, however, be remembered that they only promote their own graduates, and it is here where the Edinburgh College has sinned. It should only have promoted its own licentiates. If it had done so we should not have had this outcry.

I do hope, however, that good may come out of this adverse opinion as to the granting of the Fellowship, and hope the Edinburgh College will see its way to institute an examination for its higher qualification, even at the expense of another charter. If it cannot do this, then why not do like the university, have a thesis on a surgical or scientific subject, and also limit the promotion to its own licentiates? It would then compel aspirants to be examined, although they might have some other surgical diploma; and from what I know of the licence of the College, I can say that the examination will bear comparison with any of the other corporate, and even some of the university, examinations. One of your correspondents seems to make light of the examination for the licence; evidently he is newly fledged, or is not even tolerably acquainted with older surgeons who possess *only* the licence of the Edinburgh College as qualifying for practice. When I was a student, a few years ago, men were rejected who a few weeks after were capped for the degree of M.B. The older licentiates, however, will tell you that the Edinburgh College was, as it is now, with the exception perhaps of one or two corporations, the only college which gave a *complete* examination in all branches of medical science, and this certainly is a great thing to say, when we find our London College only *now* taking steps to do the same.

I am, Sir, yours, &c.,

Wigan, Jan. 24th, 1881. WM. BERRY, M.R.C.S. Eng., &c.

To the Editor of THE LANCET.

SIR,—Are you aware that the R.C.S. Edinburgh have had for some time under consideration a scheme for examination for its Fellowship?

I applied about three months since for admission (under examination), having seen that some of the "Fellows" placed the magic words "exam." after their names. I was in reply informed that this was under an "old" statute, and that I could only be admitted under the existing rules, but that they hoped very speedily to promulgate some new ones for holding examinations similar to the English College.

I think this should be generally known, and I should feel obliged if you would give this the same prominence as other letters upon this subject, in justice to the Edinburgh College of Surgeons, who have intended altering the present state of affairs, prior to your justly-merited leader upon the sale of "highest" diplomas.

I am, Sir, yours faithfully,

ARTHUR PRICE, M.R.C.S. Eng., &c.

Great Smith-st., Westminster, S.W., Jan. 25th, 1881.

STATISTICS OF OVARIOTOMY.

To the Editor of THE LANCET.

SIR,—At the meeting of the Royal Medical and Chirurgical Society, to which Dr. Bantock refers in his letter of Jan. 15th, I entered a strong protest against the system of rediscussing in the journals papers which have been fully discussed before the Society. This is my reason for keeping silence under the battery of letters with which we have been edified, and in which my work has received its full share of attention. I intend to adhere to my resolution. When I have fresh facts to bring forward I shall publish them, and do not fear the verdict of the profession. Having written so many letters, Dr. Bantock is naturally in doubt as to which of them I referred to. The reference was to one which appeared in the *Medical Times and Gazette* in August last.

A suggestion has been made that a committee should be appointed to watch the results of Listerian and non-Listerian ovariotomy. I think the suggestion a good one, and if an impartial committee can be formed I shall not only be happy to facilitate their observations on my future practice, but shall be glad to give them access to all my case-books since I commenced abdominal section.

I am, Sir, truly yours,

J. KNOWSLEY THORNTON.

Park-street, Grosvenor-square, W., Jan. 29th, 1881.

THE NEW FORM OF GAG.

To the Editor of THE LANCET.

SIR,—Will you allow us to state that the "improved" ring-catch with notches, for which Messrs. Mayer and Meltzer claim credit, was the original form as made by us for Mr. Rose? The serrations, however, were found to do more harm than good, as they were apt to jam the operator's fingers and pinch the patient's face, as well as to prevent the ready adjustability of the instrument. They were therefore abolished, and the requisite fixation secured by "draw-filing" the opposing surfaces.

We were under the impression that Messrs. Mayer and Meltzer were aware of this, as we find in their Catalogue, Fig. 431, a woodcut of a double-ended gag, *with* the serrations now claimed as original, described as "W. Rose's double-ended gag." It is not for us to go into the question of the advantages or disadvantages of tongue-plates, but our experience as instrument makers has been in conformity with the wishes of our customers, to use them as little as possible. Indeed, the gags constructed by us for the late Sir W. Fergusson, Mr. John Wood, Mr. Francis Mason, and Mr. W. Rose, have been especially designed with the view of getting rid of tongue-plates altogether.

We remain, Sir, your obedient servants,

MATTHEWS BROS.

Carey-street, W.C., Jan. 24th, 1881.

MANCHESTER.

(From our own Correspondent.)

ON Wednesday last an experimental meeting of the Medical Society was held in the Memorial Hall, Albert-square, the outcome of a feeling amongst some of the members that a more centrally situated place of meeting should be provided than Owens College, where the Society's meetings have hitherto been held. The meeting was very well attended, and the cases presented were of unusual interest. The general feeling of the members, however, seemed to be that the very desirable advantages of the central position and greater accessibility of the new room were rather marred by its bad lighting and general dinginess. In this connexion we may mention that it has long been the earnest desire on the part of the medical profession here that our magnificent library should be housed in a building actually situated and specially designed for the purpose, and which would contain spacious rooms for holding the monthly and other meetings of the Medical Society. This scheme, however, has never been properly set on foot, owing to the large expenditure such an undertaking would entail.

A nucleus for a building-fund has just unexpectedly been formed by the generous donation of £150 by Dr. Humphreys, who, when he was with us, always took a lively and practical interest in the welfare of the Society. This sum was the amount (with a small addition by Dr. Humphreys) subscribed by the medical profession here as a slight token of the sympathy felt for him on his leaving Manchester. It is to be hoped that the small beginning will grow, and act as an example for others to do likewise, until a fund is established which will provide for the erection and maintenance of a building worthy of the medical profession, the medical library, and an ornament to the city.

The Edinburgh University Club had its annual gathering on Friday last at the Queen's Hotel, when forty-six members sat down to a most *recherché* dinner. The chair was occupied by Professor Gamgee of Owens College. The usual loyal toasts were proposed, and some excellent speeches were delivered on the occasion, the proceedings being enlivened at intervals by songs of a national character. It was a noteworthy feature of the meeting that no reference was made either to Robert Burns or Dr. Chalmers—a circumstance probably unparalleled in the history of Scottish assemblies.

I now pass to the consideration of a more serious subject and one more intimately bound up with the interests of the coming race of medical practitioners. I wish to draw attention to the great mass of good educational material which is going to waste in our midst. We have *inter alia* three large medical charities devoting themselves to the treatment of special diseases—viz., the Children's Hospital, Pendlebury, the large Gynæcological Hospital of St. Mary, and the Royal Eye Hospital, second only in size to Moorfields, institutions which draw their patients from the teeming population of the surrounding manufacturing districts. These charities are officered by men of capacity, undoubted talent, and teaching power, but the number of students who avail themselves of their privileges is very small. This may arise from a variety of causes. Pendlebury Hospital can never by its position (four miles from the town) become a teaching centre; the other two hospitals are, however, centrally placed, and close to one another. The student of to-day may be over-lectured and over-examined, but he incurs a serious responsibility should he commence practice without a good knowledge of special subjects, which can only be adequately obtained in hospitals where large numbers of selected cases can be brought under his observation. Be the causes what they may, I am certain that a vast impetus would be given to the diffusion of special medical knowledge were these institutions recognised in some way by the licensing boards, either by accepting certificates, or otherwise. A stimulus of this sort is wanted to make the medical officers take the initiative in the formation of clinical classes, in which work they would no doubt have the hearty co-operation of their respective boards of management.

However, it is certain that something should be done, and that speedily, to instil life into the project, and thereby open up these vast storehouses of practical experience and knowledge. To this important subject I will return on a subsequent occasion, when I shall be fully armed with statistics to support my thesis.

EDINBURGH.

(From our own Correspondent.)

AT one of the recent Health Lectures for the people some interesting statistics of infant mortality were given from reports furnished by Dr. Littlejohn, the medical officer of health. In the New Town the death-rate was 18 per 1000, the mortality above five years of age was 13 per 1000, that below five years was 67 per 1000. In the Old Town the mortality was 30 per 1000; above five years 19 per 1000, under five years 108 per 1000; while in certain localities of the Old Town the mortality was specially great, as, for instance, in the Grass market, where the mortality reached 137 per 1000.

The general meeting of the infirmary contributors was held in the City Chambers on the 10th inst. The report presented stated that the experience of the first year's occupation of the new infirmary had been highly satisfactory. It was found that on contrasting the expenditure of the past year with that incurred in the old building, say in 1878, when about a similar number of in-door patients were treated, the increase amounted only to £2688; and it was stated that the managers were taking steps to manage the heating and lighting in a more economical manner. The additional accommodation for students in the clinical lecture rooms has been supplied, and the expense has been already covered by the students' fees. Attention was also drawn to the fact that infectious cases were not treated in the new building, and it seemed to be the opinion of many present that a separate fever hospital should be established, since the revenue of the present infirmary did not admit of the support of such an institution. The suggestion that the Local Authority should purchase the old hospital for the benefit of the city, using part of it for paying patients, or for various sanitary purposes, and so being prepared for epidemics, was favourably received.

Mr. Spence lately trephined in a case where inflammatory symptoms appeared after an injury. On dividing the dura mater pus escaped. The patient is doing pretty well, but has become aphasic.

MEDICAL NOTES IN PARLIAMENT.

IN the House of Commons on Thursday, the 20th inst., a petition was presented from Surgeon Malachi O'Dwyer, for redress of grievances in connexion with the Medical Service of the East India army. The second reading of the Medical Appointments Qualification Bill was deferred to Tuesday. A Bill to amend the law relating to coroners in Ireland was brought in by Mr. Healy, Mr. Gray, and Mr. Barry, and put down for second reading on Friday, 28th inst. Mr. Litton gave notice that he would ask leave to introduce a Bill to extend to Ireland some provisions of English and Scotch law as to the care of lunatics.

On Friday a further petition *re* the East Indian Army Medical Service was presented from Surgeon W. A. Manson for redress. On the motion of Mr. Pell returns of pauperism were ordered for every English county.

On Monday Mr. Barclay put a question with regard to the scheme for reconstructing Gordon's Hospital, Aberdeen, which Sir W. V. Harcourt was unable to answer, owing to the absence from London of the Lord Advocate. A Return was ordered of the report of a recent Poor-law Inspector's inquiry at Dromore Workhouse. Mr. Litton brought in his Irish Lunatics Bill, which was read a first time. The names on the back of the Bill are those of Mr. Findlater, Sir Thos. McClure, and Mr. Litton. A petition was presented from Samuel C. Amesbury for inquiry into the East India Medical Service. A return was ordered of a recent inquiry at Belfast Workhouse.

On Tuesday Sir H. Maxwell asked the President of the Board of Trade what steps, if any, were being taken, or contemplated, in order to protect British producers from unfair competition, caused by the importation from America of spurious compounds resembling, and in many cases sold to and by retail dealers as butter; and whether, in view of the rapidly increasing exports of oleomargarine, suine, soapstone, &c., from America to Holland, and the rapidly increasing exports of dairy produce by the latter country to

this country, any safeguards were maintained against the importation of such spurious compounds from Holland. Mr. Chamberlain said the subject had been for some time past engaging the careful attention of the Board of Trade, and very recently, as the hon. baronet might have seen, a paper had been printed and circulated which gave a considerable amount of information with respect to the manufacture of those compounds. It would appear from the statements of experts that in the majority of instances those manufactured butters were not unwholesome; and, under those circumstances, it was difficult to see how their importations could be prohibited. At the same time it was, no doubt, very desirable for statistical and other reasons that they should be imported under their right names. The hon. bart. referred in his question to cases in which he said those compounds had been sold to and by retail dealers as butter. He could only say in those cases that he imagined the Adulteration Act would afford a remedy for such malpractices. Sir H. Maxwell asked if the right hon. gentleman was quite sure with regard to the wholesomeness of the compounds. Mr. Chamberlain said he did not speak from personal experience in the matter, but merely from the reports furnished to him. Sir A. Gordon gave notice of a question for Friday as to famine in Southern Afghanistan, and Mr. Parnell gave notice of an inquiry as to "distress and misery" in Kanturk Union Workhouse. Mr. Warton gave notice that he will move the rejection of the Coroners (Ireland) Bill.

The usual Wednesday sitting of the House did not take place, owing to the "all night sitting" of Tuesday.

On Thursday Mr. Shaw Lefevre was questioned as to his refusal to allow snow from the streets to be carted into the parks, and gave as his reason that it spoilt the grass.

Obituary.

NATHANIEL HENRY CLIFTON, F.R.C.S. ENG., J.P., ISLINGTON.

SOME practices are the creation of one man. A larger number represent a principle of continuity, not to say heredity. The name of Mr. Clifton carries the people of Islington back more than a hundred years. And yet over all this time a large section of the people of Islington have enjoyed the privilege of being attended by Mr. Clifton or his immediate ancestors. It is not the least credit of the family that for this more than century of work only three successive members of the family have been necessary. The subject of our present notice was wont to tell how his grandfather took up his abode, lodging with a worthy baker, in Cross-street, Islington, over a hundred years since. Mr. Clifton's grandfather was born in 1751, and was in practice before 1778. He died in 1822 in Cross-street, and was succeeded by his son Nathaniel Clifton, who was born in 1786, and died in 1861 — all in Cross-street. Here too Mr. Nathaniel Henry Clifton was born Nov. 29th, 1818, and here, we are sorry to have to tell, he died on Friday, Jan. 21st, 1881, in his sixty-third year. There is an element of permanence, a faithfulness to groove and place, in most good families which is not to be unnoted. Cross-street, as it exists now, may not seem to passers through a romantic spot, to which to fix one's existence, but to a man of Mr. Clifton's character, with its historical baker's shop, which, by the way, still, we believe, survives, it had a claim and a charm to which the new-built villa has no pretensions.

Mr. Clifton was educated at the Charterhouse and at the Proprietary School, Islington. He entered Bartholomew's Hospital in 1837. He was made a governor of the hospital then or soon after. Subsequently he was put on the House Committee, and for thirty or forty years continued to take a very active personal interest in the work.

Mr. Clifton's character was one that compelled the respect of men of all parties, and especially of members of his own profession, by whom he was looked up to as a guide and friend in circumstances of difficulty and in questions of conduct. He himself was a model of professional behaviour. His benevolence took varied and quiet forms, and will be greatly missed, not least by many who enjoyed, for little or no pecuniary consideration, his continuous and careful professional attendance. The Islington Dispensary, the Medical Benevolent College, and other kindred institutions, lose by his death a cordial supporter. He was for many years treasurer of the Islington Savings Bank, of which his father was one of the founders.

Himself a Conservative and an active member of his party, Mr. Clifton could conduct his political or even ecclesiastical contests without acerbity. So high did Mr. Clifton stand in public estimation, that a few years ago he was made a Justice of the Peace for Middlesex, a position in which his professional judgment and his long and extensive knowledge of the district stood him in good stead. Mr. Clifton was, we believe, the only member of the profession on the Middlesex Bench.

Mr. Clifton's practice was extensive and arduous, including a large number of obstetric cases. His labour was increased by the great kindness of his disposition, which induced him to wait long and well on patients or families that were in trouble or sickness, even when his professional services were not of immediate use. His professional judgment was good. He was very methodical in his habits, going out and coming in with the regularity of the clock. Some of his habits were peculiar, and showed that a great deal of strength underlay the genial kindliness of his nature. Pleasure was always subordinated to work. After qualifying in 1841 he took a week's holiday. Thereafter he went for thirty-seven years without twenty-four hours' holiday. His holiday, which consisted chiefly of a few hours' fishing, was always preceded by a day's work. Within these sharply defined limits he found time to dine with a friend or take part in public affairs. He made a point, in the late hours of the night, of making up his books and his list of patients for the morrow. If he were disturbed at night, as he was very often, he never went back to his bed on returning home, but took such rest as he could get in an easily extemporised position in his study.

For a few years past the large and powerful frame of Mr. Clifton had shown signs of impairment and failure, and for a few months past it had been only too evident that his public work was done. His resignation, a few weeks ago, of the Membership of the Medical Society, of which he was one of the founders, was accepted with deep regret and pain by the members. Diabetes and albuminuria, with various and painful secondary consequences, involved a long illness, in which he was most affectionately nursed by his sisters, who have now to feel his absence. Mr. Clifton was never married. A few years ago he took into partnership Mr. Frank Godfrey, who will have to conduct the practice that for a century has been so well conducted by Mr. Clifton and his family.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the required examination for the diploma, were duly admitted Members of the College at a meeting of the Court of Examiners on the 20th inst.:—

Ashton, Charles Ernest, Guildford-street.
Bolton, Alfred, Warrington.
Breach, James Henry, L.S.A., Yattenden, Newbury.
Clark, Oscar William, Cowick, near Selby.
Collins, George William, Adelaide-road.
Cooper, Walter, L.S.A., Croydon, Surrey.
Cartayne, Herbert Maxwell, Melbourne, Victoria.
Falls, William Coultard, Buckingham palace-road.
Inger, John William, Nottingham.
Lunn, Ernest Craven, L.S.A., Hull.
Mason, John, Kirkby Stephen.
Roe, Robert Bradley, Melbury, Dorset.
Roth, Reuter Emerick, Wimpole-street.
Stokes, Arthur Samuel, Caldecott, Leicester.
Thomas, John, L.R.C.P. Lond., Ystalyfera, South Wales.
Webster, John Arthur, Manchester.

The following gentlemen were admitted Members of the College on the 21st inst.:—

Alexander, C. A. A., B.A. Cantab., Ardrossan, N.B.
Atkinson, Thomas Renel, Dawlish.
Beattie, Henry, Albert-square.
Boot, Arthur Edward, Harrington-square.
Briggs, Christopher Duffield, Tamworth.
Brooks, James, Blackburn.
Brunton, Charles Edward, East Dereham.
Clapp, George Tucker, Exeter.
Coxwell, Charles Fillingham, B.A. Cantab., Brighton.
Davis, Charles Daniel, Kilburn.
Fielden, William Eckett, Walthamstow.
Harris, Underwood Arthur C., Tufnell-park.
Hawksworth, Herbert Byfield, Canterbury.
Holthouse, Edwin Hermus, B.A. Cantab., Helidon, Northampton.
Jones, Thomas Wm. Carmall, Westbourne-street.

King, Thomas Mason, Windermere.
Rygate, Robert Edward, Wellington, N.S.W.
Squire, John Edward, Orchard-street.
Thomas, Stanley Temple, Churchdown.
Wöhrnitz, Ferdinand Broer Mathiew, Mauritius.

The following gentlemen were admitted Members of the College on the 24th inst.:—

Baker, James Barrington, Bassett-road.
Clatworthy, Herbert, L.S.A., Chatham.
Glassington, Charles William, Fulham-road.
Greswell, Daw Astley, Louth.
Harper, James, Windsor.
Johnson, Geo. Lindsay, M.A. Cantab., Upper Norwood.
Marsh, George Ryding, Greenhithe, Kent.
Meaden, George Anderson, Raymond-buildings.
Newcombe, Frank, L.S.A., Derby.
Nicholls, William John, Washingborough, Lincoln.
Oakeley, John Lewis Bagnall, Bournemouth.
Orchard, Alfred, Ashby-de-la-Zouche.
Revell, George Toms, Ivy Bridge, Devon.
Scott, Bernard, Brighton.
Starling, Edwin Alfred, Sutton, Surrey.
Studer, Benjamin, L.S.A., Linthal, Alsace.
Sutton, Samuel Walter, L.R.C.P. Lond., Reading.
Taylor, Frederic Ernest, Derby.
Tyrrell, Charles Robert, Hornsey-lane.
Ward, Lawrence Thomas, Mile-end-road.

The following gentlemen were admitted Members of the College on the 25th inst.:—

Brookes, Robert, Croft, near Leicester.
Gripper, Walter, M.B. & B.A. Cantab., Onslow-square.
Johnston, Walter, St. Mary's-square.
Macnutt, George Augustus, Barnet, Herts.
Palmer, John Irwin, Blackheath.
Smith, Gilbert Thomas, Richmond-crescent.
Watson, Solomon George, Tottenham.

The following gentlemen were admitted Members of the College on the 26th inst.:—

Biden, Edward James, L.S.A., Peckham.
Crossley, Charles, L.R.C.P. Edin., Leicester.
Downes, Charles Haggar, L.S.A., Sydenham.
English, Edgar, L.S.A., Whitby.
Kidd, Arthur, Liverpool.
Legge, William Heneage, L.S.A., Derby.
Lewis, William Henry Phillips, Guilsford, S. Wales.
Mahomed, Arthur G. Salieman, L.S.A., Brighton.
Rogers, James Macdonald, L.S.A., Berners-street.
Smith, Henry, L.S.A., Plumstead, Kent.
Whistler, Charles Watts, Ashburnham.

Of the 168 candidates admitted to examination during the past fortnight, 99 passed to the satisfaction of the Court and obtained their diplomas; 10 passed in Surgery, and when qualified in Medicine will be admitted Members; the remaining 59 failed to reach the required standard, and were referred for six months' further professional study. Two candidates who had passed in Surgery at previous examinations, having subsequently obtained a medical qualification recognised by the College, were also admitted Members.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on Jan. 20th:—

Blythe, Joseph Charles, Hendidley, Newtown, Mon.
Dancy, Horace Michael, Turner's-hill, Crawley.
Girdler, Geo. Toussaint, Westminster Hospital.

The following gentlemen also on the same day passed their Primary Professional Examination:—

Arthur Edensor, Guy's Hospital; Edward Ferdinand Grün, London Hospital; Harold George Hathway and Arthur Lloyd Macleroy, St. Bartholomew's Hospital; Hugh Stott, St. Mary's Hospital.

At the Preliminary Examination in Arts held at the Hall on Jan. 21st and 22nd, 84 candidates presented themselves, of whom 45 were rejected, and the following 39 passed and received certificates of proficiency in General Education:—

FIRST CLASS (in order of merit).—1st: Cornelius Clement Caleb. 2nd: W. V. Carden and Caroline Keith. 4th: Josephine L. MacDonogh.

SECOND CLASS (in alphabetical order).—H. D. Adcock, Jas. Anderson, A. H. Armstrong, G. P. Barton, John Bate, L. Bathurst, H. G. Beville, J. Blackford, C. Campbell, A. E. Carey, C. Christopherson, Elizabeth S. Collier, Horace S. Collier, Jessie Crosfield, William Davies, A. C. Gaskin, T. Greaves, E. T. Gregory, G. C. Harrington, J. J. Lewington, E. H. Lingwood, B. MacDonogh, A. J. H. Montague, Elise Morgan, F. J. Neville, F. Norman, C. C. Piper, R. J. Reece, Eliza Jane Stacey, Oswold E. Swete, E. S. Wallis, Lydia Maria Webb, W. P. West, Frank F. White, Harrie Yeo.

COLLEGE OF PHYSICIANS IN IRELAND.—At the January examinations the following obtained the licence in Medicine and Midwifery of the College:—

MEDICINE.—Humphrey John Brcomfield.
MIDWIFERY.—Robert Samsele Archer, Humphrey John Broomfield, Nicholas John Halpin (Surgeon, Bengal Army).

The undermentioned Licentiates have been admitted Members:—

James Berry Kenny, Alex. Lane, George Lyndon, Hugh Warnock.

LORD WINDSOR has been elected President of the Children's Hospital, Birmingham.

DR. THOMAS W. THURSFIELD has been placed on the Commission of the Peace for the borough of Leamington.

MR. W. T. DREW, L.R.C.P. Ed., &c., of the Egham District of the Windsor Union has received the Government grant for successful vaccination (fourth time).

MR. J. A. KINGDON, F.R.C.S., has resigned his honorary surgeoncy of the City Dispensary—a post which he has held for thirty years.

EXPLOSION IN AN INFIRMARY.—The boiler in the kitchen of the Tiverton Infirmary exploded on the 22nd inst., while the domestics were at dinner. One boy was killed on the spot, and a nurse was severely injured. The cook escaped almost unhurt. The room was completely wrecked.

FORTY anti-vaccinationists were brought up at the Bradford police-court on the 17th inst. charged with neglecting to have their children vaccinated. In none of the cases was the offence denied, and the defence was "conscientious objection." The Bench, in some of the cases, only inflicted a fine of 6*d.*, remitting the costs altogether, while in other cases orders were made to have the children vaccinated within three months. Most of the defendants had been previously summoned and convicted of a similar offence.

COLLEGIATE LECTURES.—The annual courses of lectures will be commenced at the Royal College of Surgeons on the 2nd prox., by Professor Parker, F.R.S., who will deliver nine lectures on the Structure of the Skeleton in the Sauropsida, to be followed by Professor Flower, F.R.S., who will give nine lectures on the Anatomy, Physiology, and Zoology of the Cetacea. Professor Butlin will continue his course on the Relations of Sarcoma to Carcinoma. Professor Treves will deliver one lecture on the Pathology of Scrofulous Affections of Lymphatic Glands. Professor Hutchinson will follow with six lectures on the Laws of Inheritance in Relation to Disease. Finally, Professor Gerald Yeo will give three lectures on the Contractile Tissues.

BOOKS ETC. RECEIVED.

BELL, G., & SONS.
A Manual of Dissections of the Human Body, for the Use of Students &c. By R. E. Carrington, M.D. Lond. pp. 200.

BLAKISTON, P., Philadelphia.
Drainage for Health, or Easy Lessons in Sanitary Science. By Jos. Wilson, M.D. pp. 68. With Illustrations.

CHURCHILL, J. & A., London.
Year-book of Pharmacy; with the Transactions of the British Pharmaceutical Conference at Swansea, August, 1880. pp. 606.
The Diseases of the Bladder and Prostate Gland. By Walter J. Coulson, F.R.C.S. Sixth Edition. pp. 607. With Illustrations.
The Student's Guide to the Diseases of Women. By A. L. Galabin, M.A., M.D., F.R.C.P. Second Edition. pp. 395. With Illustrations.
Lectures on Syphilis. Delivered at the Harveian Society, Dec. 1876, by J. R. Lane, F.R.C.S. Second Edition. pp. 94.
Carpenter's Principles of Human Physiology. Edited by Henry Power, M.B. Lond., F.R.C.S. Ninth Edition. pp. 1097. With Illustrations.

FANNIN & Co., Dublin.
Anatomy of the Arteries of the Human Body. By J. Hatch Power, F.R.C.S.I. Third Edition. By William Thomson, F.R.C.S. pp. 320. With Illustrations.

LEA'S SON & Co.
A Treatise on the Principles and Practice of Medicine. By Austin Flint, M.D. Fifth Edition, Revised and largely Rewritten. pp. 1150.

LIPPINCOTT & Co., Philadelphia.
On the Construction, Organisation, and General Arrangements of Hospitals for the Insane. By T. S. Kirkbride, M.D., LL.D. Second Edition, with Revisions, Additions, and New Illustrations. pp. 320.
Atlas of Skin Diseases. By Louis A. Duhring, M.D. Part VIII.

LIVINGSTONE, E. & S., Edinburgh.
An Investigation into the Microscopic Anatomy of Interstitial Nephritis. By B. C. Waller, M.D., F.R.C.S. Ed.

LONGMANS, GREEN, & Co., London.
A Dictionary of General Biography. By William L. R. Cates. Third Edition, Revised throughout, and Completed to the present time. pp. 1483.
Popular Lectures on Scientific Subjects. By H. Helmholtz. Translated by E. Atkinson, Ph.D., F.C.S. Second Series. pp. 265.
The Ventilation of Dwelling Houses and the Utilisation of Waste Heat from Open Fireplaces. By F. Edwards, jun. Second Edition. pp. 178. With Diagrams.
Natural Philosophy for General Readers and Young People. Translated and Edited from Ganot's "Cours Elémentaire de Physique" by E. Atkinson, Ph.D., F.C.S. Fourth Edition. pp. 612.

MACLACHLAN & STEWART.
Practical Papers on the Materials of the Antiseptic Method of Treatment. By G. T. Beatson, M.D. Edin. (Reprinted from the *Glasgow Medical Journal*.)

NEW SYDENHAM SOCIETY, London.
Investigations into the Etiology of Traumatic Infective Diseases. By Dr. Robert Koch. Translated by W. W. Cheyne, F.R.C.S. pp. 74. With five Plates.
Lexicon of Medicine and the Allied Sciences. By H. Power, M.B., and L. W. Sedgwick, M.D. Fourth Part, Art—Caf.

PARTRIDGE, S. W.
A Plea for Mercy to Animals. By J. Macaulay, A.M., M.D. Edin. pp. 95.

PAUL, C. KEGAN, & Co.
The New Playground, or Wanderings in Algeria. By Alex. A. Knox. pp 482.

PUTNAM'S SONS, New York.
Stricture of the Male Urethra, its Radical Cure. By F. N. Otis, M.D. pp. 360. With Illustrations.
The Cause of Colour among Races, and the Evolution of Physical Beauty. By William Sharpe, M.D. New Edition, Revised and Enlarged. pp. 30.

SAMPSON LOW, MARSTON, SEARLE, & RIVINGTON, London.
Cyclopædia of Practical Medicine. Edited by Dr. H. Von Ziemssen. Vol. IX., Diseases of the Liver and Portal Vein, with the Chapter relating to Interstitial Pneumonia. pp. 928.

SMITH, ELDER, & Co., London.
A Directory for the Dissection of the Human Body. By John Cleland, M.D., F.R.S. Second Edition, Revised and Improved. pp. 182.

STREET, G. & Co.
The Indian and Colonial Mercantile Directory for 1880-81.

TREAT, E. B., New York.
How to Use the Forceps; with an Introductory Account of the Female Pelvis and of the Mechanism of Delivery. By Dr. H. G. Landis. pp. 168. With Illustrations.

TRÜBNER & Co., London.
On the Use of the Cold Pack followed by Massage in the Treatment of Anæmia. By Mary P. Jacobi, M.D., and Victoria A. White, M.D. pp. 76.

WILLIAMS & NORGATE.
Grundzüge der Physiologie des Menschen mit Rucksicht auf die Gesundheitspflege. Von Dr. J. Ranke.

The Causes, Prevention, and Treatment of After-pains; by Dr. J. R. Ranking.—Can the Mildest Form of Enteric Fever be distinguished from Acute Febrile, but Non-specific, Gastro-enteric Catarrh? by C. Bäumler, M.D.—Etudes Cliniques sur les Peptones Pepsiques; par Chapoteant, Pharmacien.—Ueber die Herstammung und Ausscherdung des Kalks im gesunden und kranken Organismus; von Dr. Schetelig.—The Carisbrooke-Magazine, Jan.—Monthly Homœopathic Review, Jan.—The Choice of Food; by D. E. Flinn, L.K.Q.C.P.I.—Why the Teeth Decay, and how to Prevent it; by H. C. Quinby.—Errors in the Diagnosis of Eye Disease; by Dr. S. Theobald, Baltimore.—Dental Education; by W. B. Macleod, L.D.S. Edin.—Anales del Circulo Medico Argentino.—The Examination of the Pulse, including a Description of the Sphygmograph; by Dr. Byrom Bramwell. (Maclachlan & Stewart.)—Westminster Review, Jan.—The Day Nursery and Crèche-Guardian School.—Etiology of Infantile Summer Diarrhœa; by Dr. A. McCook Weir.—Illustrirte Vierteljahrsschrift der ärztlichen Polytechnik.—Rocky Mountain Health Resorts; by Dr. C. Denison. Second Edit. (Houghton & Co., Boston, U.S.A.)—Therapeutic Gazette.—Contributo allo' Studio della Dismenorrea Membranosa; pel Dott. Adolfo Paggi.—Diphtheria and Bacteria; by Dr. R. R. Gregg, Buffalo, N.Y.—Victorian Review, Dec.—Practical Biopathy; by Ed. Haughton, M.D. Edin. (Wade & Co.)—Walsh's Retrospect, Jan.—Transactions of the Medical Society of the State of Pennsylvania at its Thirteenth Annual Session, held at Altoona, May, 1880.—Sunday Magazine, Feb.; Good Words, Feb. (Isbister & Co.)—Hardwicke's Science Gossip. (Bogue.)

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning, at the latest*

ANDERSON, M. S., M.B., C.M., has been appointed House-Surgeon to the Paisley Infirmary.

BRADFORD, Dr. E. H., has been appointed Surgeon to Out-patients at the Boston City Hospital (U.S.A.), vice Dwight, resigned.

CHITTENDEN, C., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Medical Agent to the Hearts of Oak, Lee and neighbourhood; the Prince Alfred; and also to the Rose of Lee and Duke of Edinburgh Sick and Benefit Societies, vice Reginald Clarke, M.R.C.S.E. Also to the Crown, the Summerfield, and the Tabernacle.

CODNER, J., B.M. & M.S., has been appointed Medical Officer to the Corfe District of the Taunton Union.

DAVIES-COLLEY, J. N. C., M.B., M.C., F.R.C.S.E., has been appointed Surgeon to Guy's Hospital, vice Cooper Forster, resigned.

DAVISON, R., M.B., M.R.C.S.E., has been appointed Medical Officer to No. 1 District Workhouse, and Public Vaccinator of the Battle Union, vice R. Smith, L.R.C.P.L., M.R.C.S.E., resigned.

DINNEN, W. T., L.K.Q.C.P.I., M.R.C.S.E., has been elected Honorary Surgeon to the Flintshire Dispensary, Holywell.

DITCHETT, W. E., M.R.C.S.E., L.S.A.L., has been appointed Medical Officer to the Louth District and the Workhouse of the Louth Union, vice W. D. Ditchett, deceased.

FAGGE, C. H., M.D., F.R.C.P., has been appointed Physician to Guy's Hospital, vice Habershon, resigned.

FARMER, E. W. W., M.R.C.S.E., L.S.A.L., has been appointed Resident Medical Officer to the Seamen's Infirmary and Royal Dispensary, Ramsgate.

FINLAY, D. W., M.D., C.M., M.R.C.P.I., has been appointed Lecturer on Forensic Medicine at the Middlesex Hospital School of Medicine.

FISHER, T. W., M.D., has been appointed Superintendent of the South Boston Lunatic Asylum (U.S.A.), vice Walker, resigned.

FLACK, J., L.R.C.P., M.R.C.S.E., has been appointed Medical Officer to the City of London Lying-in Hospital, for the Bethnal-green District, vice W. Owen, resigned.

GILROY, J., L.F.P. & S., L.M., has been appointed Parochial Medical Officer and Vaccinator for the Parish of Middleborough, Dumfriesshire, vice G. R. Underwood, M.B., resigned.

HIRONS, G. M., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed an Honorary Surgeon to the Bournemouth General Dispensary.

LOVE, A. E. B., M.R.C.S.E., L.S.A.L., has been appointed an Honorary Surgeon to the Bournemouth General Dispensary.

LUDWIG, G., M.D., M.R.C.P., has been elected Honorary Assistant-Physician to the German Hospital, Dalston.

NAPIER, J., F.C.S., has been appointed Public Analyst for the Borough of Sudbury. £5 5s. per annum and fees.

OXLEY, Mr. H. R., has been appointed a House-Physician at the London Hospital, vice Wolfenden, resigned.

ROBERTS, R., L.R.C.P.Ed., L.F.P.S.G., has been appointed Medical Officer to the Llanfairtalhaiarn District of the St. Asaph Union.

ROUÉ, W. B., M.B., C.M., has been appointed one of the Visiting Physicians to the Bristol Hospital for Sick Children and Women.

STOKES, A. W., F.C.S., has been appointed Public Analyst for the Parish of St. Matthew, Bethnal-green, vice Tidy, resigned.

SWABY-SMITH, C., M.R.C.P.Ed., M.R.C.S.E., has been appointed by the Director-General A.M.D. Medical Officer in Charge of H.M. Troops at Seaforth Battery.

TICEHURST, A. R., M.R.C.S.E., L.S.A.L., has been reappointed Surgeon to the Children's Convalescent Home, St. Leonards-on-Sea.

TOWNLEY, A. T., L.F.P.S.G., has been appointed Medical Officer of Health for the Oswaldtwistle Urban Sanitary District, for one year, vice Booth, deceased.

WILSON, R. J., F.R.C.P.Ed., M.R.C.S.E., has been reappointed Physician to the Children's Convalescent Home, St. Leonards-on-Sea.

Births, Marriages, and Deaths.

BIRTHS.

APPLEYARD.—On the 30th October, at Berriedale Cottage, Longford, Tasmania, the wife of James Appleyard, J.P., M.R.C.S.E., & L.S.A.L., of a son.

BODY.—On the 13th inst., at Crediton, Devon, the wife of H. Marten Body, M.R.C.S.E., of a daughter.

CAMPBELL.—On the 20th inst., the wife of William Campbell, L.R.C.S.Ed., of Wellington-square, Hastings, of a son

COLLINS.—On the 22nd inst., at St. Austell, Cornwall, the wife of Walter C. Grocott Collins, M.D., of a daughter.

ELLIOT.—At Cliffe House, Ruyton Eleven Towns, Salop, the wife of Henry F. Elliott, F.R.C.S.E., of a son.

FRANCIS.—On the 22nd inst., at Bourton, Dorsetshire, the wife of George P. Francis, Surgeon, of a son.

GRABHAM.—On the 18th inst., at Madeira, the wife of Michael C. Grabham, M.D., F.R.C.P., of a daughter.

MYRTLE.—On the 19th inst., at Harrogate, the wife of A. S. Myrtle, M.D., of a son.

RICE.—On the 12th inst., at Swift's Hospital for the Insane, Dublin, the wife of William Rice, F.R.C.S., Medical Superintendent, of a son.

SANKEY.—On the 14th inst., at Sandywell-park, Gloucestershire, the wife of Arthur O. Sankey, Esq., of a son.

MARRIAGES.

BATTISS—FRANCKEISS.—On the 11th inst., at St. Mary's, Kingston, W. S. Battiss, M.R.C.S.E., to Laura F. Franckeiss.

DANIELL—KIRKMANN.—On the 19th inst., at St. Mark's, Kennington, Herbert E. Daniell, M.B., of Strood, Kent, to Edith, youngest daughter of the late W. Kirkmann, Esq.

HUTCHINSON—HOOD.—On the 20th inst., at Christ Church, High Harrogate, by the Very Rev. Canon Gibbon, M.A., Vicar of the Parish, S. J. Hutchinson, Esq., of Brook-street, Grosvenor-square, London, and Acton, Middlesex (son of the late Samuel Hutchinson, Esq., of Manchester), to Jeannie, youngest daughter of G. Hood, Esq., of Grosvenor Villas, Harrogate.

DEATHS.

CLIFTON.—On the 21st inst., at his residence, Cross-street, Islington, Nathaniel Henry Clifton, F.R.C.S.E., aged 63.

GREGOR.—On the 17th inst., at Institution-road, Elgin, Robert Gregor, M.D., aged 69.

HARLAND.—On the 20th inst., at Chillingworth House, Tunbridge Wells, Sarah Frances Julia, wife of Henry Harland, M.D., formerly of Mayfield and Wadhurst, aged 45.

WOOD.—On the 25th inst., at his residence, Darnaway-street, Edinburgh, suddenly, Andrew Wood, M.D., F.R.C.S.Ed.

WRIGHT.—On the 19th inst., at 128, Walworth-road, of acute laryngitis, Arabella Hutfield, the beloved wife of Morden Wright, M.R.C.S.E., L.S.A.L.

N.B.—*A fee of 1s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

Medical Diary for the ensuing Week.

Monday, Jan. 31.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

MEDICAL SOCIETY OF LONDON.—8½ P.M. Dr. Brunton, "On a Case of Gunshot Wound of the Brain of twenty-nine years' standing (the specimen will be shown)."—Mr. Edmund Owen will exhibit three Children who have recovered from Abscess in the Knee-joint after simple free drainage and rest.—Mr. Francis Mason will show (1) the specimen of Disease of the Testicle, taken from the patient brought before the Society in November last. (2) The patient shown at this Society in 1875 with Tumour of the Palate. (3) A Case of Removal of Upper Jaw five years after the operation.

Tuesday, Feb. 1.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 3 P.M.

ROYAL INSTITUTION.—3 P.M. Professor Edward A. Schäfer, "On the Blood."

PATHOLOGICAL SOCIETY OF LONDON.—8½ P.M. The following specimens will be shown:—Case of Strangulated Hernia; Ruptured Aorta; Three Cases of Recurrent Multiple Sarcoma; Localised Scleroderma (living specimen); Congenital Truncation of Forearm; Unilateral Hypertrophy of Head; Drawings of Localised Scleroderma; Sacral Tumour containing Fœtal Structures; Case of Abscess of the Liver; Case of Chloasma.

Wednesday, Feb. 2.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1 P.M.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

EPIDEMIOLOGICAL SOCIETY.—8 P.M. Dr. Squire, "On Instructions for Vaccine Inoculation."—Surgeon-General C. A. Gordon, "On certain Considerations regarding Cholera and Fever, more especially with reference to India and China."

OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Annual Meeting; Election of Officers and Council, President's Address, and other communications.

SOCIETY FOR THE ENCOURAGEMENT OF ARTS, MANUFACTURES, AND SCIENCES.—Mr. Stephen Bourne, "On Trade Prospects."

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor W. K. Parker, "On the Structure of the Skeleton in the Sauropsida."

Thursday, Feb. 3.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

ROYAL INSTITUTION.—3 P.M. Mr. Francis Hueffer, "On the Troubadours."

HARVEIAN SOCIETY.—8½ P.M. Dr. Hughlings Jackson, "On a Case of Temporary Hemiplegia after Localised Convulsion."—Dr. Fletcher Beach, "On Types of Imbecility."

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC.—5 P.M. Dr. Ramskill, "On the Treatment of some Forms of Epilepsy."

Friday, Feb. 4.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—8 P.M. Dr. A. Wilson, "On Colonial Organisms."

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor W. K. Parker, "On the Structure of the Skeleton in the Sauropsida."

Saturday, Feb. 5.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—3 P.M. Prof. S. Colvin, "On the Amazons."

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, January 27th, 1881.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radia in Vacuo	Max. Temp Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Jan. 21	30·22	N.E.	24	..	..	30	19	..	Foggy
,, 22	30·30	N.W.	19	..	..	35	14	..	Overcast
,, 23	30·22	N.W.	35	33	..	38	21	..	Overcast
,, 24	30·27	E.	29	..	..	30	25	..	Foggy
,, 25	30·04	E.	26	..	..	31	22	..	Overcast
,, 26	29·76	E.	22	..	..	29	16	..	Overcast
,, 27	29·30	S.E.	39	39	..	43	29	..	Overcast

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Local papers containing reports or news-paragraphs should be marked.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

Lectures, original articles, and reports should be written on one side only of the paper.

We cannot prescribe, or recommend practitioners.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

FROST, FLOODS, FOGS; SNOWS, SEWERS AND SANITATION.

OUR recent experiences in regard to the weather are happily altogether exceptional. The long-continued frost, with the complication of fogs, has exercised a most depressing effect on most persons, although the infliction is not without its collateral good influences on the few who, being in excellent health or enjoying the mental disposition distinguished by Charles Dickens in the character of Mark Tapley, are able to respond to the provocation of external cold by the acceleration of their internal heat-production. Moreover it is believed by good authorities that the early snow and frost, if not unduly prolonged, will act advantageously on the process of seed germination and vegetation generally, so that hereafter the crops may be larger and better for the repression they are now suffering. It would be well if we could hope that the cold would exercise a salutary effect on the public health by arresting the progress of contagious and infectious diseases. Unhappily, however, there is reason to fear the huddling together for warmth and crowding in-doors, certain to ensue among the poor in consequence of the intense cold, will concentrate, and thereby intensify, the virulence of "catching" diseases to an extent which must more than antagonise any beneficent action which the low temperature might otherwise exert on the morbific germs. Moreover it is always necessary to remember that if cold to some extent checks the activity of disease, it in a more than corresponding degree lowers the vitality of the organism, and thus diminishes the natural safeguards against its invasion. The floods which have occurred—to the lasting disgrace of our domestic government—have caused and will certainly yet entail much grievous suffering and manifold maladies. The snow in our streets is not simply an obstacle to traffic, but a source of danger to health. Either intentionally or in the process of an occasional thaw it will find its way into the sewers, and the sewer gas can scarcely fail to be driven back into the houses. How much better it would be to provide the country with a representative Minister of "public health" in Parliament than to allow these matters of detail to be dealt with piece-meal! The country might be saved considerable expense and the population serious disease if only the interests of "public health" were gathered into a focus and recognised at head-quarters by a Government careful of home affairs and the welfare of the people not less than of those questions which occupy statesmen more than they benefit the people at large.

MEDICAL PRACTITIONERS IN QUEBEC.

M.R.C.S. ENG., L.S.A.—There are, we believe, about a thousand licensed medical practitioners in the province of Quebec, which is in the proportion of nearly one to every hundred of its population.

EXAMINATIONS AT THE ROYAL COLLEGE OF SURGEONS.

THE first meeting for the present session of the Court of Examiners of the Royal College of Surgeons for the final examination of candidates for the Diploma of Membership was held on the 14th inst., when 164 candidates presented themselves, to whom the following questions on Surgical Anatomy and the Principles and Practice of Surgery were submitted, when they were required to answer at least four (including one of the first two) out of the six questions:—

1. Describe the anatomy of the parts concerned in femoral hernia, and the steps of the operation for its relief when strangulated.
2. State the facts respecting the epiphyses of the humerus, radius, and ulna, which are important in surgical practice.
3. Describe the symptoms caused, first, by a subcutaneous rupture, and, secondly, by an open wound of a popliteal aneurism. State what treatment ought to be pursued in each case.
4. Describe the fractures of the neck of the femur and the upper third of its shaft, and point out the signs and symptoms by which they are diagnosed.
5. Under what circumstances would you recommend the removal of the eyeball? Describe the operation and the after-treatment.
6. How would you recognise uric acid in the urine? First, by the naked eye; secondly, by the microscope. State the principal conditions under which it is met with.

The following were the questions on the Principles and Practice of Medicine submitted to those candidates who had not previously obtained any recognised medical licence:—

1. Whence are hydatids derived? What organs do they chiefly infest? Discuss the morbid anatomy, symptoms, and treatment of hydatids of the liver?
2. Describe the contracted granular kidney. Mention the morbid conditions under which it is especially apt to be developed; and enumerate, and, as far as you can, explain the lesions and symptoms to which it gives rise.
3. What are the indications and counter-indications for the employment of opium? State the composition and average dose of each of the following pharmacopœial preparations:—Acidum nitro-hydrochloricum dilutum, pulvis ipecacuanhæ comp., decoctum aloes comp., pil. conii comp., pil. hydrargyri subchloridi comp., and pulv. kino comp.

SANITATION IN CHERTSEY.

WITH reference to some observations we made a fortnight ago, the *Surrey Advertiser* observes:—

"Our usually well-informed contemporary appears to be under a misapprehension in this matter. In our issue of December 25th will be found the facts as reported—the removal of the deceased (a draper's assistant) to the workhouse as a small-pox patient; the disease subsequently found to be measles, and his death on Dec. 10th, bronchitis and malignant sore-throat having set in. On Dec. 22nd the Rural Sanitary Authority held an inquiry, when none of the deceased's friends appear to have been represented, but at which a general feeling was expressed that all was right that was done. In our last issue we reported that owing to letters from the relatives of Spiers and from the Local Government Board on the matter, it was determined to ask for an inquiry to be held by the Local Government Board. This will, we trust, elicit the full facts. With reference to the closing question of THE LANCET we may remark that a 'room' in the infirmary has been set aside for small-pox patients. As to why an infectious disease hospital is not constructed apart from the workhouse, that is a question which many other places besides Chertsey would like to have answered."

A. M. D. must refer to the advertising columns of our Students' Number.

A Student.—Dunglison's, Fowler's, or Mayne's.

Dr. Redwood (Rhymney).—The reports can be obtained of the medical officer of health of the district.

Mr. Alfred Philipps.—We cannot call to mind the paper named. Probably the subject mentioned was referred to incidentally only.

"GRATITUDE FOR VACCINATION."

MR. CHALMERS MORTON, of Northchurch, writes to *The Times*, as follows:—

"SIR,—Will you allow me once more to name Stephen Jenner in your columns? Ten years ago you let me tell his story (see *The Times*, July 27th, 1871), and thanks to the contributions then and since received, a monthly payment of £2 has ever since doubled his slender income, and saved his poor circumstances from becoming intolerable. Except that three liberal annual contributors of £5 continue to stand by it, that fund is for the present exhausted. I submit that it ought to be replenished. Mr. Stephen Jenner, now in his eighty-eighth year, living at Heathfield, near Berkeley, is the grandson of Dr. Edward Jenner's younger brother. He was in his childhood himself the subject of many of the test experiments by which his great uncle discovered and established the safety conferred by vaccination. In his youth he was his uncle's favourite associate. He has led a blameless life. It is not necessary that the explanation of his poverty should be given here. It can be given to anyone who asks for it. But it is a pitiable thing that one so nearly related to so great a human benefactor should be dependent in his extreme old age on a gift of 10s. a week to save him from destitution."

MR. G. SMITH OF COALVILLE.

THE *House and Home* for Jan. 22nd contains a good portrait and an appreciative though brief *résumé* of the labours of Mr. George Smith of Coalville, whose exertions on behalf of the canal population we have had frequent occasion to notice. Mr. Smith's philanthropic efforts have been extended to the brickmakers and the gipsies, whose habits and surroundings, physical and moral, it has been his life work to endeavour to ameliorate and improve.

THE APPLICATION OF WARMTH TO THE HEAD.

To the Editor of THE LANCET.

SIR,—In many cases of partial or complete suspended animation, especially those connected with cold, valvular defects, and stillbirth, I would suggest the trial of the application of warmth to the head.

I am, Sir, your obedient servant,

CHARLES YOUNG, Surgeon, &c.

Chilton-Polden, Jan. 18th, 1881.

THE TERMS OF ATTENDANCE ON ODDFELLOWS.

To the Editor of THE LANCET.

SIR,—In reply to the letter of Mr. Lys in your last number, permit me to state that the Loyal Good Intent Lodge (No. 6264) pays its medical officer five shillings a year for each member residing within three miles of the lodge-house, "and in no case will sick pay be granted to those whose sickness is brought on by their own misconduct"—extract from rules.

I am, Sir, yours faithfully,

Watford, Jan. 26th, 1881. F. H. WILSON ILES.

Dr. J. H. Battye.—Silicon lozenges can, we believe, be obtained through any druggist.

Mr. W. A. Dingle.—If our correspondent will refer to Guy and Ferrier's Forensic Medicine (p. 529), he will find among *occasional* symptoms of opium poisoning "delirium, convulsions (most common in children), sometimes alternating with stupor, &c." So that Mr. Irving, in order to personate the chief part of a tragedy, must have descended to imitating *occasional symptoms, most common in children.*

G. A.—We have no recollection of the paper.

WANTED—A DIAGNOSIS.

To the Editor of THE LANCET.

SIR,—I wish to report a case I attended some time since, which I think may be of interest to the profession, and on which I would like the opinion of some of my medical brethren as to what was the disease and what the cause of it. On August 11th I was called to see a little girl, aged four years, named A. C——. I found her sitting on her grandmother's knee, face flushed, and extremely fretful, so that it was very difficult to examine her. I found on inquiry, however, that she complained of great pain in her head, and some in her back and limbs; bowels were constipated; tongue coated of a yellowish colour; breath very offensive. I diagnosed worms and bilious fever. I prescribed santonine, calomel, and quinine in small doses. On the 14th I called to see the child again, who appeared much better—so much so that I considered it unnecessary to return unless sent for. On the 15th I inquired after the child, and was told that she was still better. On the evening of the 16th I was sent for in great haste, with the message that the child was dying. I went as soon as possible, and found it lying on its bed. Breathing easy; temperature 101°; pupils of eyes dilated and insensible to light; quite unconscious; head hot, extremities comfortable. From what I could learn it had had tetanic spasms, and since had fallen into this comatose condition. I prescribed cold to head, sinapisms to feet and legs, quarter of a grain of calomel every two hours, and a mixture of bromide and iodide of potassium.—17th: Still in same condition. Put a blister at the back of the neck, and gave a dose of castor oil and turpentine; afterwards continued treatment as before.—18th: Child completely roused up, and wanted to eat. She partook during the day plentifully of crackers and milk and a very little chicken broth. Bowels had been moved several times, and thirteen worms had been expelled by them, and one vomited. On the evening of the 18th and morning of the 19th she suffered from tetanic spasms again, relapsing into a comatose condition.—20th: Little change, but in the evening swallowing appeared difficult for the first time, and her friends gave no medicine. Another doctor was sent for, without my knowledge, on the 21st, and called the case one of cerebro-spinal fever. He found the child, who I saw shortly after, with a temperature of 103°, pupils still dilated, and the right eye drawn inwards, looking towards the nose. He prescribed a mixture containing ten drops of tincture of belladonna and five grains of bromide of potassium every two hours, also hot boiled corn to spine. On the 22nd I met and told him that I thought the cerebro-spinal symptoms which existed were due to reflex action caused from irritation set up by ascarides, and I finally got him to tell the friends that the state of matters then existing might not be spinal fever proper (as stated by him on the previous day, when I was not present), but might be, using his words, "caused by cholera infantum, fever and ague, or worms, &c." The child died the same evening. Now, what I wish to know is, was this a case of spinal fever? From the history I think not, but that worms were the exciting cause of the cerebro-spinal trouble. Apologising for encroaching on your valuable time and space, I am, Sir, yours respectfully,

WATSON L. KING, M.D., &c.

Ohio, Oct. 25th, 1880.

THE CORONERS' ACT OF ONTARIO.

THIS measure, passed at the last session of the Ontario Parliament, appears to have given rise to much questioning and dissatisfaction in the Canadian mind. One feature at least in the new Act certainly seems remarkable. It is enacted (we quote from the *Canada Lancet*) that a coroner must, before issuing his warrant, make a declaration in writing and on oath before a magistrate that he believes, from information received, that the deceased did not die from natural causes, but from negligence or foul play, and that therefore an inquest is required. This is surely a cumbrous and vexatious method of putting a check on any tendency that may be exhibited to hold unnecessary inquests.

PROTECTION AGAINST UNJUST OBSTETRIC JUDGMENTS IN COUNTY COURTS.

To the Editor of THE LANCET.

SIR,—A case has just been tried in a county court in which I figured as plaintiff in respect of a midwifery engagement, a verbal agreement only, without witnesses, constituting the basis of the action, and it is in consequence of an adverse verdict that I deem it my duty to lay the particulars before you and your numerous readers, and to ask what course in respect of these engagements ought medical men to pursue in order to protect themselves against the repudiation, partial or complete, of a verbal midwifery engagement by the patient or her friends?

And now as to my own case. I was requested by an artisan earning good wages to attend his wife, and as the distance from my residence to his was more than a mile and a half, I informed him that my fee would be two guineas, which at the time he agreed to pay, but afterwards, the case being over, he paid me one guinea, repudiating his liability for the other, together with a further charge of ten shillings and sixpence for four bottles of quinine mixture which it became necessary to prescribe subsequently. Here let me remark that I paid eight visits to the patient during the following fortnight, for which no charge was made.

As to the case itself, it was one of placenta prævia in a primpara, there being, in addition, adhesion of the placenta, and, to add to its perils, she was weak from a previous illness. I was with her the whole night, and, to complete the history, both mother and child did well. I stated to the judge that the case was beset with difficulties and perils from the commencement to the end, informing him also as to the time during which I was engaged with the patient, and to strengthen my position as opposed to the statement of the husband, who made the agreement with me, and swore that I said my fee would be one guinea, and not two, I handed to the judge my visiting-list, in which I had at the time entered the engagement and fee specified—viz., two guineas.

His Honour objected to medicine being charged for at all in connexion with midwifery cases, commented upon the easy manner in which some cases come over, as a set off, I suppose, against my remarks upon the serious character of the case in connexion with which he was to deliver judgment; and, notwithstanding my explicit declaration to the effect that I stated to the husband when the engagement was made that, "Owing to the great distance, my fee would be two guineas," and the husband's reply, "that he should like his wife to have the best attendance and advice, and that he would rather I attended her than anyone else," his Honour gave a verdict for the defendant, against which I protested, without avail.

And now, Sir, I will leave the matter in your hands and in those of my professional brethren, and ask how are we to protect our interests and obtain justice if such a verdict is to be looked upon in future as a precedent.—I am, Sir, your obedient servant,

LABUS.

Nov. 18th, 1880.

P.S.—I enclose my card, and ought, I think, to add that I lost the major portion of a day in seeking for justice, without finding it.

*** This letter speaks for itself as a caution to general practitioners.—ED. L.

D. M. R. may consult Mr. Lawson Tait's recent pamphlet on the subject. We have no doubt that a note addressed by our correspondent to that gentleman (Birmingham) would elicit the information he desires.

A Would-be Emigrant had better apply to Moore and Co., St. Mary-axe.

ERRATA.—In the notice of the *Quarterly Journal of Microscopical Science* last week, in the fourth line, for "Welwillschia mirabilis," read *Welwitschia* mirabilis. In the tenth line, for "Endoderm of Quinocodium, read *Endoderm Limnocodium*.

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British Workman, Science, La Union de la Ciencias Médicus, Hampshire Post, Stratford-upon-Avon Herald, Royal Cornwall Gazette, Sunday Figaro, Gaceta Médica Catalana, House and Home, Hampshire Telegraph, Retford and Gainsborough Times, La Escuela de Medicina, Hastings and St. Leonards Observer, Warehousemen and Drapers' Trade Journal, Journal of Applied Science, Glasgow Herald, Dumfriesshire and Galloway Herald, Scotsman, Civil and Military Gazette, &c., have been received.

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